

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 06152 248

1. PLACE OF DEATH:

County Prince GeorgesCity or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 dayHospital, institution, or street address where death occurred:
Eugene Leland Memorial HospitalHow long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia CountyCity or town Roseville
(If outside city or town limits, write RURAL and give nearest town)Street No. -
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Allen, Richard Lee, Jr.

3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Mrs. Bernice Beatrice Allen6.(c) If alive, give age 25 years7. Birth date of deceased (mo., day, yr.) September 21, 19148. AGE: Years 31 Months 8 Days 22 If less than one day
.....hrs.min.9. Birthplace Roseville, Virginia
(Town, county, and state)10. Usual occupation Truck Driver11. Industry or business H. R. Heflin12. Name Richard Lee Allen13. Birthplace Roseville, Va.14. Maiden name Dora Ethel Burryman15. Birthplace Stafford, Va.16. Informant Mrs. Bernice Beatrice AllenAddress Roseville, Virginia17. Burial Date thereon June 16, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St. John CemeteryLocation Stafford Co. - Garrisonville Va18. Funeral director F. G. Gosh's sonsAddress Staffordville Md.19. June 15, 1946 James Seery
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 19 46 at 10:37 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death ToxemiaDue to hypertension of the bodyDue to Arteriosclerosis of the bodyOther conditions Arteriosclerosis of thearm at elbow
(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6-8-46Where did injury occur Baltimore Pro Se Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public placeMeans of injury Change in car. Injured at work? yes23. SIGNATURE James Seery M. D. or otherAddress Frederick Md. Date signed 6-12-46

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JUN 15 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of
given name of deceased is
shown on
FILM NO. 106 AUG 22 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

06153

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince GeorgesCity or town Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

Prince Georges Hosp.How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County WashCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 450 PR. Place
(If rural, give LOCATION)2.(a) If veteran, name war ☒

3.(a) FULL NAME

anshaugh, Mrs. Bessie

3.(b) Social Security Number

4. Sex

F

5. Color or race

w

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife John A. Anshaugh7. Birth date of
deceased (mo., day, yr.)July 7 1877

6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

69—— hrs. _____ min.

9. Birthplace

md.

(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

FATHER

12. Name

Dawson Wilkison

13. Birthplace

md.

14. Maiden name

Julia Stete

15. Birthplace

md.

16. Informant

mi.L.B. Hail

Address

6256 Marebas Pike S.E. Wash

17. (Burial, cremation, or removal. Which?)

Date thereof

June 26, 1946

Cemetery or crematory

Inter-Federal Home

Location

Hagerstown md

18. Funeral director

H. Giacchi, son

Address

Hyattsville md

19.

6/25/46Amanda Dorney

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

6-241946 at 6 35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19 1946 to June 24 1946and that I last saw him alive on June 24 1946

Immediate cause of death

myocardial
occlusion

DURATION

24 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William Brannin

M. D. or other

Address

Capitol Hgts, md.

Date signed

6/24/46

ACTS IN LEDGER

TRAG KONTENT

RECEIVED
JUN 27 1946
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06154

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 months
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 4 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1005 - 2nd St. N. E.
 (If rural, give LOCATION)
 2. (a) If veteran, name war -

3. (a) FULL NAME

BAILEY, LINWOOD

3. (b) Social Security Number

568-30-0166

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 8. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) December 10, 1928
 8. AGE: Years 17 Months 6 Days - If less than one day hrs. min.

9. Birthplace Wadesboro, North Carolina
 (Town, county, and state)
 10. Usual occupation Presser
 11. Industry or business

FATHER 12. Name George Bailey
 13. Birthplace Wadesboro, North Carolina
 MOTHER 14. Maiden name Mary Bennett
 15. Birthplace Wadesboro, North Carolina

16. Informant Decedent

Address
 17. Removal to Date thereof June 11, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory
 Location Washington, D. C.

18. Funeral director John T. Stewart
 Address 307 H. St. N.E. Wash. D.C.

19. June 10, 1946 Registrar Rowland S. Phillips
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 19 46, at 10²⁵ P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
2/11 19 46, to 6/10 19 46
 and that I last saw him alive on 6/10 19 46

Immediate cause of death pulmonary tuberculosis
 DURATION 6 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Finucane M.D. M. D. or other

Address Glenn Dale, Md. Date signed 6/10/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUN 19 1946

BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06155

Reg. Dist. No. 245

1. PLACE OF DEATH:

County

Pro Geo Co

City or town

Hyattsville Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Pro Geo Co

City or town

Hyattsville Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

4195 Decatur st.,

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Hazen Baker

3. (b) Social Security Number

4. Sex

female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Robert A Baker

6.(c) If alive, give age 48 yrs

7. Birth date of

deceased (mo., day, yr.)

May 12, 1892

8. AGE:

Years

Months

Days

If less than one day

54

hrs.

min.

9. Birthplace

Washington D. C.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Wm John Holmes

13. Birthplace

Washington D. C.

14. Maiden name

Estelle Kimell

15. Birthplace

Washington D. C.

16. Informant

Robert A Baker

Address

Hyattsville Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof June 25, 1946

(month) (day) (year)

Cemetery or crematory

Arlington Cemetery

Location

Arlington Virginia.

18. Funeral director

F. Gasch 's Sons

Address

Hyattsville Md.

19.

(Date rec'd by registrar)

1946

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 21

1946

at

1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-21-46

19

to

6-21

1946

and that I last saw h.

on

6-20-46

19

Immediate cause of death

Coronary occlusion

DURATION

2 wks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John P. Cum M.D.

M. D. or other

Address

Hyattsville Md.

Date signed 6-21-46

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JUN 24 1946

BUREAU V.S.

VETERAN LETTER

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(13-2)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 66158231

1. PLACE OF DEATH:

Country Prince GeorgesCity or town Cheney
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:

Prince Georges Hosp.How long in hospital or institution? 6 days

3. (a) FULL NAME

Banner, Mr. Oscar

3. (b) Social Security Number

4. Sex

m

5. Color or race

w

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Mrs. Delia Banner

7. Birth date of

deceased (mo., day, yr.)

May 27, 1898

8. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

68

hrs.

min.

9. Birthplace

Tennessee
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

William Banner

13. Birthplace

N. C.

MOTHER

14. Maiden name

Margaret A. Albridge

15. Birthplace

N. C.

16. Informant

Mrs. Delia Banner

Address

Glendale Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

June 15, 1946
(month) (day) (year)

Cemetery or crematory

Fort Lincoln

Location

Cottage city Md.

18. Funeral director

F. Pascha sons

Address

Spatterville Md.

19.

(Date rec'd by registrar)

19. 46Amanda Journey

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Prince GeorgeCity or town Glendale
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-13 19 46 at 4:40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-8 19 46 to 6-12 19 46

and that I last saw him alive on

6-12 19 46Immediate cause of death Art. obstructCardio. Vascular
Disease

DURATION

3 years

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Banner

M. D. or other

Address

Int. Rainier Md.Date signed 6-13-46

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JUN 15 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93D

CERTIFICATE OF DEATH

06157

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince GeorgesCity or town near Hyattsville, D.C.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 1/2 yearsHospital, institution, or street address where death occurred
Walter Jones Rest Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Va CountyCity or town Blacksburg
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____ ✓

3. (a) FULL NAME

Lucy E. Bennett

3. (b) Social Security Number

4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced widow

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1865 8. (c) If alive, give age _____ years8. AGE: Years 80 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Blacksburg Va
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business _____

12. Name Franklin Wall

13. Birthplace _____

14. Maiden name Annie Robinson

15. Birthplace _____

16. Informant Maith Jones Rest HomeAddress Hyattsville17. Buried Date thereof Oct 2/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Geo. Wash. Mem. PkLocation Hyattsville, Md18. Funeral director Wm Chaenker & CoAddress Riverdale, MdDate June 12 1946 J. Lewis Beery

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1946, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 1943, to June 10 1946and that I last saw him/her alive on recently 1946Immediate cause of death apoplexyDue to arteriosclerosisDue to sinusitisOther conditions chronic hypertension

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. Allen Griffith M. D. or otherAddress Berwyn, Md Date signed 6/10/46

DURATION

1 weeksmallsp. an.smallyearsmallyear

RECEIVED
JUN 14 1946
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
City or town (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 7 mos., 14 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 2 yrs., 7 mos., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State D. C. County _____
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. Little Sisters of The Poor, D. C.
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

Courtney Blair

3. (b) Social Security Number

None

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married (separated)

B. (b) Name of husband or wife Mamie Turner Blair

7. Birth date of deceased (mo., day, yr.) August 14, 1876 6. (c) If alive, give age 54 ? years

8. AGE: Years 69 Months 9 Days 27 It less than one day _____ hrs. _____ min.

9. Birthplace Charles County, Maryland
(Town, county, and state)

10. Usual occupation Fisherman

11. Industry or business

FATHER 12. Name John Blair
13. Birthplace Charles Co., Maryland

MOTHER 14. Maiden name Lucy Washington
15. Birthplace Charles Co., Maryland

16. Informant Decedent

Address _____

17. Removal Date thereof June 11, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location to Washington, D. C.

18. Funeral director J. H. Lowe
Address 2426-2 st n.w.

19. June 10, 1946 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 19 46, at 1:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 23 19 43, to June 10 19 46
and that I last saw him alive on June 10 19 46

Immediate cause of death _____ DURATION _____
Pulmonary Tuberculosis 3 yr.
Due to Aneurysm Aorta 3 yr.
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Pinicane MD M. D. or other _____
Address Glenn Dale Md Date signed 6/10/46

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 19 1946

BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 460

CERTIFICATE OF DEATH

06159

Reg. Dist. No. 239

1. PLACE OF DEATH:

Couely Prince GeorgeCity or town Laurel, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Gwynne Page Bouis

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ruth King Bouis

7. Birth date of

deceased (mo., day, yr.)

July 24 1885

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

601026

hrs.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Rent Examiner Inspector

11. Industry or business

O. P. A. Office

FATHER

12. Name

Stephen Bouis, Jr.

13. Birthplace

Baltimore, Md.

MOTHER

14. Maiden name

Achsah G. White

15. Birthplace

Howard Co., Md.

16. Informant

Mrs. Ruth K. Bouis

Address

132 Lafayette Ave, Laurel, Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

June 22, 1946

(month) (day) (year)

Cemetery or crematorium

National Capitol Mem. Park

Location

Muirkirk, Md.

18. Funeral director

DeWitt Donaldson

Address

106 Main St., Laurel, Md.June 22, 1946
(Date rec'd by registrar)M. Beashear
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Laurel, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 132 Lafayette Ave.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20, 1946 19..... at 6:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-1-1946 to 6-20-1946
and that I last saw him alive on 6-20-1946

Immediate cause of death

Cardiac Dilatation

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B. P. Warm

M. D. or other

Address Reverend Inc Date signed 6-22-46

RECEIVED
JUN 25 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

C6160

Reg. Dist. No. 245

1. PLACE OF DEATH:
 Prince Georges County
 County.....
 Brentwood Maryland
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 22 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 Maryland Pro Geo County
 State..... County.....
 Brentwood Maryland
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3816 Bunker Hill Road.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
 Elizabeth G. Boyle

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife.....
 D. (c) If alive, give age .. years
 7. Birth date of deceased (mo., day, yr.) May 28, 1892
 8. AGE: Years 54 Months Days If less than one day
 .. hrs. .. min.

9. Birthplace Connecticut
 (Town, county, and state)
 10. Usual occupation Health teacher
 11. Industry or business
 12. Name James Boyle
 13. Birthplace Unknown
 14. Maiden name Mary Clarking
 15. Birthplace Unknown

16. Informant Miss Vera R. Parker
 Address Brentwood Md.

17. Burial Date of death June 14, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Churchville Cemetery
 Location Churchville Maryland.
 F. Gasch's Sons

18. Funeral director
 Address Hyattsville Maryland

19. Date rec'd by registrar June 12, 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 1946. 9:30A M
 .. 19 .. 21 .. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 5-31 .. 1946, to 6-11 .. 1946
 and that I last saw her alive on 6-11 .. 1946

Immediate cause of death
 Coronary occlusion
 DURATION 1 day

Due to Coronary Heart Failure 3 yrs

Due to ..

Other conditions ..

(Include pregnancy within 3 months of death)

Major findings of operations ..

.. Date of op. ..

Autopsy results ..

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .. Date of ..

Where did injury occur? .. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ..

Means of injury .. Injured at work?

23. SIGNATURE .. M. D. or other

Address .. Date signed 6-12-46

RECEIVED

JUN 14 1946

BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

06161

1. PLACE OF DEATH

County Pr. Geo.

Village or City Bowie

No.

Registration Dist. No. 243

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 10 yrs. 0 mos. 0 ds. How long in U.S. if of foreign birth? 0 yrs. 0 mos. 0 ds.

2. FULL NAME

Charles Joseph Brown

U.S. Veteran specify WAR

(a) Residence: No.

Bowie

md

St.

Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Colored

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year)

May 28 - 18 98

7. AGE

Years

Months

Days

If LESS than
1 day, 0 hrs.
or 0 min.

48

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.

Elevator Operator

9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.

10. Date deceased last worked at
this occupation (month and
year)

11. Total time (years)
spent in this
occupation

12. BIRTHPLACE (city or town)

(State or country)

Washington D.C.

FATHER

13. NAME

Charles Joseph Brown

14. BIRTHPLACE (city or town)

(State or country)

md

MOTHER

15. MAIDEN NAME

Ida Mary Prout

16. BIRTHPLACE (city or town)

(State or country)

md

17. INFORMANT

(Address)

Ida Mary Brown
Bowie md

18. BURIAL, CREMATION, OR REMOVAL

Place

Bowie

Date

July 5, 1946

19. UNDERTAKER

(Address)

Martin Fladung Sons
Bowie md

20. FILED

July 4, 1946
Mrs. J. W. Gierling
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

June

30

1946

(Month)

(Day)

(Year)

22.

I HEREBY CERTIFY, That I attended deceased from

, 1946, to July 5, 1946.

I last saw h. June 30 alive on June 30, 1946; death is held

to have occurred on the date stated above, at 10 m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:

Cardiac renal disease

Date of onset

Sudden

Other Contributory Causes of Importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of Injury

, 1946

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

John H. Maloney acting sup.
Chesley, Maryland M. D.

MARGIN RESERVED FOR BINDING

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

06162

239

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

2. (a) If veteran, name war

3. (b) Social Security Number

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

23. SIGNATURE

Address

M. D. or other

Date signed

RECEIVED
JUN 18 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month, 10 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 1 month, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1405 - A. St. S. E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____ ✓

3. (a) FULL NAME

FRANCIS BROWN

3. (b) Social Security Number

1 ?

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single
 8.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) July 9, 1913
 8. AGE: Years 32 Months 11 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Washington, D. C.
 (Town, county, and state)
 10. Usual occupation None
 11. Industry or business _____
 12. Name Patrick Brown
 13. Birthplace Clinton, Maryland
 14. Maiden name Bertha Shields
 15. Birthplace Washington, D. C.

16. Informant Decedent
 Address _____
 17. Burial Date thereof 7-3-46
 (Burial, cremation, or removal? Which?) (month) (day) (year)
 Cemetery or crematory Lincoln Memorial Cemetery
 Location Southland Md.
 18. Funeral director George A. Betty & Sons
 Address 1203 Walter St. S.E.
 19. June 30, 1946 Rowland S. Phillips
 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30th 1946 at 12²⁰ P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20th 1946 to June 30 1946
 and that I last saw him alive on June 30 1946
 Immediate cause of death Pulmonary Tuberculosis DURATION 2 mos
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Pinecone MD M. D. or other _____
 Address Glenn Dale Md. Date signed 6/30/46

RECEIVED

JUL 9 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

 06164
 Reg. Dist. No. 231

1. PLACE OF DEATH:

 County... Prince Georges
 City or town... 5301 Upshur St N Decatur
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Olive Ford Byford

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mr Mety J Byford

7. Birth date of

deceased (mo., day, yr.)

1894

8. AGE:

52

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Penna

(Town, county, and state)

10. Usual occupation

Agriculture Dept

11. Industry or business

John W Ford

FATHER

12. Name

John W Ford

13. Birthplace

Penna

MOTHER

14. Maiden name

Unknown

15. Birthplace

Penna

16. Informant

Mr Mety J Byford

Address

5301 Upshur St N Decatur Hgts

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

June 24, 1946

Cemetery or crematory

Hines Funeral Home

Location

2901-14 St NW Washington

18. Funeral director

The N. N. Jones Co.

Address

2901-14 St NW

19. Date rec'd by registrar

June 24, 1946

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Prince Georges

City or town

5301 Upshur St

(If outside city or town limits, write RURAL and give nearest town)

Street No.

N Decatur Hgts Md

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 23, 1946

at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 3, 1946

to

June 23, 1946

and that I last saw her alive on

June 2, 1946

Immediate cause of death

terminal pneumonia and toxemia

Due to

Epidermoid carcinoma

Due to

secondary with distant metastases

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Biopsy

Date of op.

June 45

Physician's results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Lawrence H. Wickinson MD

M. D. or other

Address

11404 Queenbury Rd

Date signed

June 23, 1946

RECEIVED

JUL 1 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46f

06165

FILM No. I 06 JUL 17 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Georges County

City or town Rivendale, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, institution, or street address where death occurred:

Leland Memorial Hospital.

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)

Street No. 201 Washington Blvd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Emma Burke.

3. (b) Social Security Number

4. Sex

F.

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband

Walter J. Burke.

6. (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.)

August 4, 1892

8. AGE:

53

Years

Months

10

Days

39

If less than one day

hrs.

min.

9. Birthplace

Laurel, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

owned home.

FATHER

12. Name

Edward N. Fink

13. Birthplace

Laurel, Md.

MOTHER

14. Maiden name

Emma Lee

15. Birthplace

Laurel, Md.

16. Informant

Walter J. Burke

Address

Laurel, Md.

17.

(Burial, cremation, or removal) Which?

Date thereof

July 1, 1946

Cemetery or crematory

St. Hill Cemetery

Location

Laurel, Maryland

18. Funeral director

St. Hill Funeral Home

Address

105 Main St. Laurel, Md.

19.

(Date rec'd by registrar)

1946

June 30

1946

James S. Sery

Registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1946, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 22 1946, to June 28 1946.

and that I last saw him alive on June 28 1946.

Immediate cause of death

Carcinoma Liver
Colon. Ulcer
Omentum
Pancreas

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. B. Fink
Laurel

M. D. or other

Address

Date signed

June 28/46

RECEIVED

JUL 5 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137-07

CERTIFICATE OF DEATH

06166

Reg. Dist. No. 239

1. PLACE OF DEATH:

County... Prince Georges
 City or town... Laurel
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Prince Georges
 City or town... Laurel
 (If outside city or town limits, write RURAL and give nearest town)
 Street No...
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME

Marie Fredricka Busse

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Aug 13, 1903

8. (c) If alive, give age... years

8. AGE:

Years 42 Months Days If less than one day

9. Birthplace

Brehme, Germany

10. Usual occupation

Own home

11. Industry or business

FATHER MOTHER

12. Name... Marie Busse

13. Birthplace... Brehme, Germany

14. Maiden name... Marie Fredricka Busse

15. Birthplace... Brehme, Germany

16. Informant... Personal papers

Address

17. Burial Date thereof June 10/46

Cemetery or crematorium... St. Luke's

Location... Laurel, Md.

18. Funeral director... St. Luke's

Address... Laurel, Md.

19. June 9, 1946 in Bussears

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... June 7, 1946 at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him... alive on 19...

Immediate cause of death

Acute congestive heart failure

Due to Cardiovascular renal disease

DUE TO

DUE TO

DUE TO

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... James J. Busse

Address... Forestville Md. Date signed... 6-8-46

RECEIVED

JUN 11 1946

BUREAU V F

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 06167 232

1. PLACE OF DEATH:

County Prince George's
 City or town Marbleton R.F. D # 2
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? four days
 Hospital, institution, or street address where death occurred:
Mo
 How long in hospital or institution? ~

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George's
 City or town Upper Marlboro P.F.D.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Baby Catterton

3. (b) Social Security Number

4. Sex 5. Color or race 6. (c) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife Aug 11

7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age _____ years

June 16 1946

8. AGE: Years Months Days If less than one day

4

9. Birthplace Upper Marlboro Md

(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

12. Name James H. Catterton13. Birthplace Wash., D.C.14. Maiden name Ida Mae Grierson15. Birthplace Lothian Md16. Informant Ida Mae CattertonAddress Upper Marlboro, Md17. Buried Date thereof 6-21-46

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory First LincolnLocation Bladenburg, Md.18. Funeral director W. F. L. L. L.Address Upper Marlboro, Md.19. June 21 1946 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 19 46, at 10:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 16 19 46, to June 20 19 46and that I last saw him alive on June 20 19 46Immediate cause of death MalnutritionDURATION 4 daysDue to Premature Birth

(Pregnancy about 8 months)

Due to _____

Other conditions Secondary Anemia

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. _____

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James P. Ancker

M. D. or other _____

Address Upper Marlboro Date signed 6-20-46

REC-1111
JUN 24 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1240

CERTIFICATE OF DEATH

06168
Reg. Diat. No. 242

1. PLACE OF DEATH:

County Prince George
City or town Seat Pleasant, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Seat Pleasant
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6211 Field St.
(If rural, give LOCATION)
2. (a) If veteran, name war none

3. (a) FULL NAME

MARTHA DELILAH CLARK

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white widow

6. (b) Name of husband or wife Daniel J. Clark

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10th 1868

8. AGE: Years Months Days If less than one day
78 4 19 5 hrs. 55 min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation none

11. Industry or business none

12. Name Richard Jones

13. Birthplace Maryland

14. Maiden name Elizabeth Owens

15. Birthplace Maryland

16. Mrs Rebecca L. Moreland

Address 6211 Field St. Seat Pleasant Md.

17. Burial Date thereof 7-1-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt Zion

Location Mt Zion Md.

18. Funeral director W. W. Chambers Co.

Address 517 11th St. S. E.

19. June 30, 1946 Registrar Carrie F. Campbell

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29, 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 15, 1945 to June 29, 1946

and that I last saw him alive on June 27, 1946

Immediate cause of death Chronic

Calcular heart

disease

Due to Cardio renal disease

Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. P. Pagan

Address Seat Pleasant Md.

Date signed June 30, 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 3 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH:

County Prince GeorgeCity or town Reston
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Transient

Hospital, institution, or street address where death occurred:

Bayne Island Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County Falls ChurchCity or town Falls Church
(If outside city or town limits, write RURAL and give nearest town)Street No. 200 Woodlawn Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Elizabeth Ann Clem

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

8.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

June 24, 1930

8. AGE:

Years 15 Months 11 Days 23 hrs. _____ min. _____

9. Birthplace

Philadelphia, Pa.
(Town, county, and state)

10. Usual occupation

Student

11. Industry or business

High school

MOTHER

FATHER

12. Name

Joseph Frank Clem

13. Birthplace

Virginia

14. Maiden name

Catherine Simmons

15. Birthplace

New York

16. Informant

Donald R. Price

Address

Falls Church, Va.

17. Burial

woodstock cemetery

Cemetery or crematory

woodstock Va

Location

F. Caschi song

18. Funeral director

Spatterville and

Address

June 17, 1946

19. (Date rec'd by registrar)

James Devay

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH June 16 1946 at 5:45 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____ to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death

Myocardial infarctionFractured skullCrushed chest

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 6-16-46Where did injury occur Bethesda, D.C. (City or town) (County) (State)Injured at home, farm, industry, public place (where) Road through farmMeans of injury Passenger in car that was a rollerReputy Med. Dir. of Health23. SIGNATURE James J. Devay

M. D. or other _____

Address Bethesda, Md. Date signed 6-16-46

INTERNAL SECURITY

RECEIVED

JUN 19 1940

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince GeorgesCity or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 24 years

Hospital, institution, or street address where death occurred:

4100 33rd StreetHow long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)Street No. 4700 33rd Street
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Annie LAURA Coleman

3. (b) Social Security Number

none

4. Sex

F

5. Color or race

Wh.

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Frank WileyColeman

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 7, 1861

8. AGE: Years Months Days It less than one day

85230— hrs.— min.9. Birthplace Tamul, Pr. Geo., Ind.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Andrew Jackson Kelley13. Birthplace Tamul, Ind.14. Maiden name Roselle Cole15. Birthplace Westminster, Ind.16. Informant Bladys LewisAddress 4100 33rd St.17. Burial Date thereof 6-8-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Woods CemeteryLocation Wash., D.C.18. Funeral director Wm. J. KelleyAddress 3200 - R. I. Ave. Mt. Rainier, Md.19. June 7, 46 James Sevey Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1946 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 12, 1946 to June 6, 1946and that I last saw him alive on June 6, 1946Immediate cause of death Coronary Thrombosis

DURATION

3 hrs.Due to Generalized Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James J. Feffer M. D. or otherAddress 2783 Wapahut St. Date signed 6/6/46

RECEIVED

JUN 10 1945

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 139

CERTIFICATE OF DEATH

 06171-242
 45-
 Reg. Dist. No.

1. PLACE OF DEATH:

County Prince GeorgesCity or town Parkland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Parkland Southeast
(If outside city or town limits, write RURAL and give nearest town)Street No. 225 1/2 Maryland Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John Thomas Conley

3. (b) Social Security Number

4. Sex male5. Color or race white6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Agnes J. Brightley

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) may 3, 19058. AGE: Years 41 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Bloomington, Maryland.
(Town, county, and state)10. Usual occupation Bricklayer

11. Industry or business

12. Name John Thomas Conley13. Birthplace ?14. Maiden name Ella Creamer15. Birthplace Maryland16. Informant Mrs. Agnes J. ConleyAddress 225 1/2 Maryland Ave.17. Burial Date thereof June 8, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. Calvary CemeteryLocation Forestville, Md.18. Funeral director Wm. J. NalleyAddress 522 8th. St. S.E.19. June 7 19 46 James Leroy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 19 46, at 2:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 19 46, to June 4 19 46.and that I last saw him alive on June 4 19 46.Immediate cause of death Pulmonary tuberculosisDURATION 10 years

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William Brannin
M. D. or other _____Address Capital Hotel, Md. Date signed 4/8/46

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE CITY OF BOSTON

RECEIVED

JUL 11 1945

BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEX: ~~male~~ ~~female~~; aff. also filmed 7-12-46 G104 LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-2)

CERTIFICATE OF DEATH

66178 245
★ Reg. Dist. No.

1. PLACE OF DEATH:

County Prince Georges
City or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 years
Hospital, institution, or street address where death occurred:
4220-34th Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4220-34th Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Arthur Thaddeus Cook

3. (b) Social Security Number

4. Sex MALE7/11/1866

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Emma A. Cook

7. Birth date of deceased (mo., day, yr.)

January 11, 18668. (c) If alive, give age 76 years

8. AGE:

Years

Months

Days

If less than one day

8058

hrs.

min.

9. Birthplace

Ohio

(Town, county, and state)

10. Usual occupation

Accountant

11. Industry or business

Retired

FATHER

12. Name

Marcellus C. Cook

13. Birthplace

Ohio

14. Maiden name

Augusta Lamert

15. Birthplace

Ohio

16. Informant

Mrs. Emma A. Cook

Address

4220-34th St., Mt. Rainier, Md.

17. (Burial, cremation, or removal. Which?)

RemovalDate thereof June 13, 1946
(month) (day) (year)

Cemetery or crematory

Location

Bethesda, Md.

18. Funeral director

Wm. Reuben Humphrey

Address

7557 Wis. Ave. Bethesda, Md.

19.

(Date rec'd by registrar)

1946

James Leary

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19, 1946 at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him... alive on 19...

Immediate cause of death

acute congestive heart failure
Cardiovascular renal disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Deputy Medical Examiner

23. SIGNATURE

James I. Boyd

M. D. Physician

Address 7 Forest Hill Rd. Date signed 6-19-46

RECEIVED
JUN 21 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (96)

CERTIFICATE OF DEATH

06173

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Pro. Bay CoCity or town 5403-37th Ave Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 mo

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County PrCity or town Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)Street No. 5403-37th Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Josephine Marian Creagham

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced8. (b) Name of husband or wife John T. Creagham7. Birth date of deceased (mo., day, yr.) Feb 12, 18648. (c) If alive, give age 82 years8. AGE: Years 82 Months - Days - If less than one day - hrs. - min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation housewife

11. Industry or business

12. Name James Jewell13. Birthplace Md14. Maiden name Sallie ?15. Birthplace Md16. Informant Carrie M. ReeceAddress 5403-37th Ave Hyattsville Md17. Burial (Burial, cremation, or removal. Which?) Date thereof June 17, 1946
(month) (day) (year)Cemetery or crematory ChaseLocation Chase, Baltimore Co.18. Funeral director H. K. McComas & SonAddress Abingdon, Md.19. June 14 (Date rec'd by registrar) 1946 James Seever Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 1946 at 11:50 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-24 1946 to 6-13 1946and that I last saw h. Pr alive on June 13 1946Immediate cause of death massive hemorrhage

DURATION

Due to Dissection aneurysmDue to This aneurysm was on aortic anteriorsclerotic basis. Wassermann and Kahn negativeOther conditions C. & G. P.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John P. Clum M.D. M. D. or otherAddress Hyattsville Md Date signed 6-14-46

RECEIVED

JUN 15 1946

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

Reg. Dist. No. 06174 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 mos., 7 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 9 mos., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1207 - 3rd St. S. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____ ✓

3.(a) FULL NAME

DAVIS, ESSIE

3.(b) Social Security Number

-

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Divorced

B.(b) Name of husband or wife ?

7. Birth date of deceased (mo., day, yr.) April 5, 1908 6.(c) If alive, give age _____ years

8. AGE: Years 38 Months 2 Days 8 If less than one day _____ hrs. _____ min.

9. Birthplace Crossett, Arkansas
 (Town, county, and state)

10. Usual occupation Finisher11. Industry or business LanndryFATHER 12. Name Walsh Davis13. Birthplace Crossett, ArkansasMOTHER 14. Maiden name Frances Tolbert15. Birthplace Crossett, Arkansas16. Informant Decedent

Address _____

17. Removal Date thereof June 14, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location to Washington, D.C.18. Funeral director John T. Rhines & Co.Address 901 - 3rd St. S.W.19. June 13, 1946 Ronald S. Philips

(If to rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 13 19 46 at 1:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPT. 6 19 45, to JUNE 13 19 46
 and that I last saw her alive on JUNE 13 19 46

Immediate cause of death Pulmonary Tuberculosis DURATION 10 mo.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Pinucane M.D. M. D. or other _____Address Glenn Dale, Md. Date signed 6/13/46

RECEIVED
JUN 19 1946
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

06175 -
105 234

1. PLACE OF DEATH:
County..... Prince Geo
City or town..... Accokeek MD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 2 yr
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... MD County..... P. Geo
City or town..... Accokeek MD
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME..... Marcus Lafayette Davis
3. (b) Social Security Number.....

4. Sex..... M 5. Color or race..... Yk 6. (a) Single, married, widowed, or divorced..... Wid
6. (b) Name of husband or wife.....
7. Birth date of deceased (mo., day, yr.)..... Feb. 1 - 1887
8. AGE: 89 Years Months Days If less than one day
..... hrs. min.

9. Birthplace..... Anst Ford MD
(Town, county, and state)
10. Usual occupation..... Merchant

11. Industry or business.....
12. Name..... William Davis
13. Birthplace..... Washington DC
14. Maiden name..... Emma Anderson
15. Birthplace..... Wash. DC

16. Informant..... Louise Vivant Smyth
Address..... 1875- Mount Pleasant Rd
17. Burial (Burial, cremation, or removal. Which?)..... Burial Date thereof..... 6-15/46
(month) (day) (year)
Cemetery or crematory..... Congressional
Location..... Washington DC

18. Funeral director..... Smith & Son
Address..... 6-5 46
19. (Date rec'd by registrar)..... 1946 M. L. Thorne Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 6-3 1946, at 7:55 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1946 to June 3 1946
and that I last saw him alive on June 2 1946
Immediate cause of death..... Cerebral hemorrhage
DURATION.....
Due to..... gen. arteriosclerosis
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)
Major findings of operations..... Date of op.

Antopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?
23. SIGNATURE..... Alchayman
Address..... 2015 Nicholson Ave Date signed..... 6/3/46

RECEIVED
JUN 11 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:

County Prince George
 City or town Laurel
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 Yr.; 11 M.; 14 D.
 Hospital, institution, or street address where death occurred:
Laurel Sanitarium
 How long in hospital or institution? 2 Yr.; 11 M.; 14 D.

2. USUAL RESIDENCE (HOME) OF DECEASED: Daughter
 (For newborn infants give residence of mother)

State Maryland County
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4202 Greenway
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Edward Jackson Diggs

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Eugenia Hapchal
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) June 3 - 1963
 8. AGE: Years 83 Months 0 Days 4 If less than one day hrs. min.

9. Birthplace Baltimore
 (Town, county, and state)
 10. Usual occupation R.R. Claim Agent
 11. Industry or business B+O R.R.
 12. Name Beverly Diggs
 13. Birthplace Baltimore
 14. Maiden name Louise B. Addison
 15. Birthplace Baltimore

16. Informant Sanitarium Records
 Address Laurel San., Laurel, Md.
 17. Burial Date thereof 6/10/46
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory St. John's Cathedral
 Location Baltimore, Md.
 18. Funeral director Thomas Goff, Inc.
 Address 1217 P. Court St.
 19. 6/7 19 46 Dr. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 19 46 at 1 A M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 24 19 43 to June 7 19 46
 and that I last saw him alive on June 6 19 46
 Immediate cause of death

Cardiac: De compensation DURATION 5 days
 Due to General Arterio Sclerosis Heart
 Due to Senility
 Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Date of op. Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of Injury Injured at work?

23. SIGNATURE John L. Wethered M. D. or other
 Address Laurel San.; Laurel Md. Date signed 6/7/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 182

CERTIFICATE OF DEATH

06176

Reg. Dist. No.

231

1. PLACE OF DEATH:

County Prince GeorgesCity or town Farmington Heights
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 mo

Hospital, institution, or street address where death occurred:

1012 - 60th Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Farmington Heights
(If outside city or town limits, write RURAL and give nearest town)Street No. 1012 - 60th Ave
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Pauline Odell Houp

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Oct 11, 1945

8. AGE:

Years

Months

Days

less than one day

729

hrs.

min.

9. Birthplace

Washington DC
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Samuel Houp

13. Birthplace

Greensboro N. C.

MOTHER

14. Maiden name

Rachel Ann Kidwell

15. Birthplace

Farmington Heights, Md

16. Informant

Mrs Rachel A Houp

Address

012 - 60th Ave, Farmington Heights

17.

Removal
(Burial, cremation, or removal. Which?)

Date thereof

6-12-46
(month) (day) (year)

Cemetery or crematory

Washington Funeral Home

Location

Washington, D.C.

18. Funeral director

F. Gasch's Sons

Address

Hyattsville, Md

19.

June 13
(Date rec'd by registrar)

19.

46Amantia Doriney
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 19 46, at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19 _____, to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death

Immersion burns
shock

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Accident

Date of

6-10-46

Where did injury occur?

Farmington Heights
(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

In house thought to be on fire
keepsy medicine

23. SIGNATURE

James D. Joy

M. D. or other

Address

Theobald AveDate signed 6-10-46

RECEIVED
JUN 15 1946
BUREAU V. &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

CERTIFICATE OF DEATH

06177

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George'sCity or town (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 11 mos., 17 days

Hospital, institution, or street address where death occurred:

Glenn Dale SanatoriumHow long in hospital or institution? 11 mos., 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. CountyCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 1026 - 8th St. N. W.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

DURHAM, MATTIE V.

3. (b) Social Security Number

578-20-9778

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) June 13, 19208. AGE: Years Months Days If less than one day
26 - 1hrs.min.9. Birthplace Winnsboro, South Carolina
(Town, county, and state)10. Usual occupation Cleaner11. Industry or business Pullman Company12. Name William Durham13. Birthplace Winnsboro, South Carolina14. Maiden name Sarah Williams15. Birthplace Winnsboro, South Carolina16. Informant Decedent

Address

17. Removal Date thereof June 15, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location to Washington, D.C.18. Funeral director John T. StewartAddress 30 H. St. N.E., Wash. D.C.19. June 14, 1946 Rouland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 19 46 at 2:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 28 19 45 to June 14 19 46
and that I last saw him or alive on June 14 19 46Immediate cause of death Pulmonary Tuberculosis

DURATION

15 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Pinucane MD

M. D. or other

Address Glenn Dale Md Date signed 6/14/46

RECEIVED
JUN 21 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (732)

CERTIFICATE OF DEATH

★06178 245

Reg. Dist. No.

1. PLACE OF DEATH:

County Prince George Co
 City or town Riverdale Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 hour
 Hospital, institution, or street address where death occurred:
Le land Mem. Hosp
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Wash DC
 City or town Belmont St
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1321 - Belmont St
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Helen Duttweiler

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single (married) married widowed, or divorcedB. (b) Name of husband or wife Le land D Duttweiler7. Birth date of deceased (mo., day, yr.) Sept 11 1896 6. (c) If alive, give age8. AGE: Years 55 Months 10 Days 11 If less than one day9. Birthplace Binghamton NY (Town, county, and state)10. Usual occupation housewife

11. Industry or business

12. Name Patrick Mc Carthy13. Birthplace Ireland14. Maiden name Mary Mahoney15. Birthplace Ireland16. Informant Sister & husbandAddress 1321 - Belmont St DC17. Removal (Burial, cremation, or removal. Which?) Removal Date thereof June 23 1946 (month) (day) (year)Cemetery or crematory 42nd Street Funeral HomeLocation Washington DC18. Funeral director The S.H. Jones CoAddress 2901 - 14th St NW19. June 23 46 Registrar Janus Bevers

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 46 at 140 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 46 to June 23 1946and that I last saw him alive on June 23 1946Immediate cause of death Pharyngeal failureDue to Angiostenosis cardiacDue to atherosclerosisOther conditions hypertensionDue to hypertensionOther conditions hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Agg. AdlyM. D. or other June 23 46Address 1252 4th St NW Date signed June 23 46

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
JUN 26 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

732

CERTIFICATE OF DEATH

06179 242
Reg. Dist. No.

1. PLACE OF DEATH:

County PRINCE GEORGE
City or town OAKLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? LIFE
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MARYLAND County PRINCE GEORGE
City or town OAKLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6393 ROLLINS AVE
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

FOWLER, MRS. RHODA

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE WHITE MARRIED

6. (b) Name of husband or wife BENJAMIN A. FOWLER

7. Birth date of deceased (mo., day, yr.) 8. (c) If alive, give age 72 years
Jan. 9th 18778. AGE: Years Months Days If less than one day
69 hrs. min.9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name JOSEPH SHAW
13. Birthplace MARYLAND14. Maiden name
15. Birthplace MARYLAND16. Informant MR. BENJAMIN LOGAN FOWLER
Address 6393 ROLLINS AVE17. Burial Date thereof 6-4-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Episcopal Church Cemetery
Location Forestville Md.
18. Funeral director W.W. Chambers & Co.
Address 517-11TH St. S.E.19. Date rec'd by registrar June 3 19 46
Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 19 46 at 12⁰⁰ P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 46 to June 2 19 46 and that I last saw him alive on June 1 19 46

Immediate cause of death 6 circulatory failure

Due to Hypertensive arterio-sclerotic heart disease 8 years

Due to Left paralysis 3 yrs

Other conditions

Major findings of operations None

Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?23. SIGNATURE Sidney W. Lowry M.D.
Address 1503 Good Hope Rd. S.E. Date signed June 2, 46
Washington 20. D.C.

RECEIVED

JUN 4 1946

BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06180

Reg. Dist. No. 246

1. PLACE OF DEATH:

County Penn GeorgisCity or town mt. Rainer
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 days

Hospital, institution, or street address where death occurred:

3300 Otis street, Mt. Rainer

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penna - County SuzerneCity or town Wilkes Barre
(If outside city or town limits, write RURAL and give nearest town)Street No. 118 - Willow street
(if rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Hayden Howard Frantz

3. (b) Social Security Number

4. Sex Male5. Color or race white6. (a) Single, married, widowed, or divorced Separated6. (b) Name of husband or wife Leatha Frantz

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Jan 4 - 18888. AGE: Years 58 Months 6 Days 22 If less than one day _____ hrs. _____ min.9. Birthplace Penna
(Town, county, and state)10. Usual occupation Contractor11. Industry or business Contractor12. Name Unknown13. Birthplace "14. Maiden name "15. Birthplace "16. Informant Mrs. Eva HusseyAddress 3300 Otis street Mt. Rainer17. (Burial, cremation, or removal. Which?) 6-26-46Cemetery or crematory Hanover Green Cem. Pa.Location Hanover Green, Penn.18. Funeral director J. William Lee's SonsAddress 300 - 4" st. N.E.19. (Date rec'd by registrar) June 26 46Registrar James Leary

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 19 46 at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death

Acute congestive heart failureDue to cardiovascular renal disease

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Manner of injury _____ Injured at work? _____

Signature James D. LearyAddress Frederick Date signed 6-26-46

RECEIVED

JUN 27 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-6

CERTIFICATE OF DEATH

06181

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1836 1/2 - 6th St. N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ✓

3. (a) FULL NAME

BEN GAITHER

3. (b) Social Security Number

251-03-0784

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

June 20, 1910

8. AGE:

Years

Months

Days

If less than one day

35

11

25

.....hrs.

.....min.

9. Birthplace.....

Fairfield, North Carolina

(Town, county, and state)

10. Usual occupation.....

Laborer

11. Industry or business.....

FATHER
MOTHER

12. Name.....

George Gaither

13. Birthplace.....

Fairfield, North Carolina

14. Maiden name.....

Minnie Aridge

15. Birthplace.....

Fairfield, North Carolina

16. Informant.....

Decedent

Address.....

17. Removal
(Burial, cremation, or removal. Which?)Date thereof June 14, 1946
(month) (day) (year)

Cemetery or crematory.....

Location.....

to Washington D. C.

16. Funeral director.....

Johnson & Jenkins

Address.....

2053 Ga. Ave., N.W., D.C.

19.

June 14, 1946. Rowland S. Phillips
(Note rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... JUNE 14 1946 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JUNE 8 1946 to JUNE 14 1946

and that I last saw him alive on JUNE 14 1946

Immediate cause of death.....

PULMONARY TUBERCULOSIS

miliary tuberculosis of lungs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Daniel Leo Pinucane M.D.

M. D. or other

Address..... Glenn Dale, Md. Date signed 6/14/46

RECEIVED
JUN 21 1946
BUREAU V.S.

COPY

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 142

CERTIFICATE OF DEATH

06182

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Georges
 City or town Riverdale
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 2/3
 Hospital, institution, or street address where death occurred:
Eugene Leland Memorial Hospital
 How long in hospital or institution? 1 2/3

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges
 City or town Hyattsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1700 60th Avenue, North Englewood
 (If rural, give LOCATION)
 2.(a) If veteran, name war -

3. (a) FULL NAME

Sheila Ruth Gortney

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife -
 6.(c) If alive, give age - years
 7. Birth date of deceased (mo., day, yr.) June 10, 1946
 8. AGE: Years Months Days If less than one day
1 2/3 hrs. min.

9. Birthplace Riverdale, Maryland
 (Town, county, and state)
 10. Usual occupation -
 11. Industry or business -
 12. Name John Taylor Gortney, III
 13. Birthplace Little Rock, Arkansas
 14. Maiden name Ruth Ione Lindstrom
 15. Birthplace Fremont, Nebraska

16. Informant Mrs. Ruth L. Gortney
 Address 1700 60th Ave., North Englewood, Hyattsville
 17. Burial Date thereof June 14 - 46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Luke's Cemetery
Wash. D.C.
 Location Wash. D.C.
 18. Funeral director W.C. Chambers & Co.
 Address Riverdale, Md.
 19. June 14 46 Registrar James Sery
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12, 1946 at 11:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10, 1946 to June 12, 1946
 and that I last saw him alive on June 12, 1946
 Immediate cause of death atelectasis

DURATION

Due to -
 Due to -
 Other conditions -
 (Include pregnancy within 8 months of death)

Major findings of operations -
 Date of op. -

Autopsy results -
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide - Date of -
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -
 Means of injury - Injured at work? -

23. SIGNATURE L. W. Mahan M. D. or other -
 Address Riverdale Md Date signed -

RECEIVED

JUN 15 1946

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

06183

Reg. Dist. No. 234

1. PLACE OF DEATH:

County... Prince George

City or town... Oxon Hill
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Prince George

City or town... Oxon Hill
(If outside city or town limits, write RURAL and give nearest town)Street No. 5550-Wheeler Rd., Washington 20, D.C.
(If rural, give LOCATION)

2(a) If veteran, name war...

3. (a) FULL NAME

Ernest H. Griffith

3. (b) Social Security Number

4. Sex Male	5. Color or race White	6. (a) Single, married, widowed, or divorced Married
----------------	---------------------------	---

8. (b) Name of husband or wife... Daisy M. Griffith

8. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) August 8th, 1903

8. AGE:	Years	Months	Days	If less than one day
42				hrs. min.

9. Birthplace... Statesville, North Carolina
(Town, county, and state)

10. Usual occupation... Salesman

11. Industry or business

12. Name... Ernest H. Griffith

13. Birthplace... North Carolina

14. Maiden name... Belle Kelly

15. Birthplace... North Carolina

16. Informant... Mrs. Daisy M. Griffith (Wife)

Address... 5550-Wheeler Rd., Washington 20, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 7-1946
(month) (day) (year)

Cemetery or crematory... Arlington National Cemetery

Location... Arlington, Va.

18. Funeral director... Thomas F. Murray

Address... 2007-Nichols Ave S.E. Washington D.C.

19. June 4 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4th 1946, at 7-P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1945 to June 4 1946 and that I last saw him alive on 6-3-1946

Immediate cause of death... Cerebral hemorrhage

DUE TO... gen. arterio-sclerosis

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations...

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury Injured at work?

23. SIGNATURE... Stewartman

Address... 2015 Nichols Ave S.E. Date signed... 6/4/46

RECEIVED

JUN 11 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 638

CERTIFICATE OF DEATH

06184

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Pr. Geo. Co.
 City or town Landonville Mills Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Md County Pr. Geo. Co.
 City or town Landonville Mills Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 7004 Taylor Terrace
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Eva Lee Grubbe

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Divorced

8. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 5 - 1882

8. AGE:

Years

Months

Days

If less than one day

64

hrs. min.

9. Birthplace

Martinsburg, W. Va
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Jno W. Kastle

13. Birthplace

W. Va

14. Maiden name

Maggie E. Prince

15. Birthplace

Pa

16. Informant

Ruth E. Myers, Sr

Address

7004 Taylor Terrace Landonville Md

17. (Burial, cremation, or removal. Which?)

Date thereof

6/6/46

Cemetery or crematory

Green Hill Cemetery

Location

Martinsburg, W. Va

18. Funeral director

W. W. Chambers & Co

Address

Riversdale, Md

19. (Date rec'd by registrar)

19 46Amanda Downey

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 5 19 46, at 3:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 3 19 46, to June 5 19 46and that I last saw her alive on June 4 19 46

Immediate cause of death

Thrombosis of abdominal aorta

DURATION

48 hr

Due to

Arteriosclerosis fibrillation 5 years

Due to

Hypertensive heart disease and hypertrophy 10 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. Louis Mendel, M.D.

M. D. or other

Address

College Park MdDate signed 6/6/46

RECORDED
JUN 8 1946
BUREAU OF

2411 N. Charles St., Baltimore (47C)

CERTIFICATE OF DEATH

Reg. Dist. No. 275

MARGIN RESERVED FOR BINDING

VS A15

9.43.13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Prince George County
City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, institution, or street address where death occurred:
Island Memorial Hospital
How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D.C. County _____
City or town _____
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1315 W. Va. Ave., D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war. _____

3. (a) FULL NAME
Selby Brinker Hollidge
4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Mary Etta Hollidge 6. (c) If alive, give age 56 years
7. Birth date of deceased (mo., day, yr.) Nov. 14, 1899
8. AGE: Years 66 Months 6 Days 6 If less than one day _____ hrs. _____ min.
9. Birthplace Brentwood, D.C.
(Town, county, and state)
10. Usual occupation Baker
11. Industry or business _____
12. Name James Bernhard Hollidge
13. Birthplace England
14. Maiden name Martha Devers
15. Birthplace Virginia
16. Informant (Son) John Albert Hollidge
Address 4515 Temple Lane
Burial Washington, D.C.
17. (Burial, cremation, or removal) Which? Burial Date thereof June 6, 1946
(month) (day) (year)
Cemetery or crematory St. Lincoln's Church
Location Waco, Tex.
18. Funeral director W.W. Chaykus
Address 577-11th St. E.
June 6, 1946 James Seery
(Date rec'd by registrar) Registrar

3. (b) Social Security Number _____

MEDICAL CERTIFICATION
2D. DATE OF DEATH June 6, 1946 at 5:00 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1946 to 6 June 1946
and that I last saw him alive on 5 June 1946
Immediate cause of death Respiratory failure DURATION 6 hrs.
Due to Melastatic Carcinoma 3-6 mo.
Due to Bronchogenic Carcinoma 8-18 mo.
(K.A.D.) Right upper bronchus
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) (Country) (State)
Injured at home, farm, industry, public place (where?) _____
Means of Injury _____ Injured at work? _____
23. SIGNATURE Sidney W. Lowry M.D.
Address 1505 Good Hope Rd. SE D. D. or other 6-6-46
Date signed _____

RECEIVED
JUN 10 1946
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1702

CERTIFICATE OF DEATH

66186

Reg. Dist. No. 230

1. PLACE OF DEATH:

County Prince George's CoCity or town Contee Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Pro Geo CoCity or town Beltsville Maryland
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(u) If veteran, name war _____

3. (a) FULL NAME

Thomas D. John

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

separated

6. (b) Name of husband or wife Bessie M JohnB. (c) If alive, give age 47 years7. Birth date of deceased (mo., day, yr.) August 14, 18968. AGE: Years Months Days If less than one day
49 years.hrs.min.9. Birthplace Front Royal Va
(Town, county, and state)10. Usual occupation Farm Superintendent11. Industry or business Beltsville Research Center12. Name Thomas J. John13. Birthplace Virginia14. Maiden name Ernestine Walter15. Birthplace Virginia16. Informant Bessie M. JohnAddress Beltsville Maryland.17. Burial Date thereof June 3, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fort LincolnLocation Colmar Manor Md18. Funeral director F. Gasch's SonsAddress Hyattsville Maryland19. 34 19 46 J. D. Daulton
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1, 1946 at 12:30 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19..... to 19.....

and that I last saw h..... alive on 19.....

Immediate cause of death..... DURATION

hemorrhagestrokeDue to Crushed chestabdomen and pelvisAlso fractured skull

Other conditions

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MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

JUN 5 1946

BUREAU V. G.

2411 N. Charles St., Baltimore 222

CERTIFICATE OF DEATH

* 061872 43

Reg. Diat. No.

1. PLACE OF DEATH: Prings George's
County.....
City or town..... (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo., 14 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 month, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... D. C. County.....
City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 2515 - 13th St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war..... -

3. (a) FULL NAME	NELLIE RAE KERNS	3. (b) Social Security Number	-
------------------	------------------	-------------------------------	---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced	
Female	Colored	Single	
6.(b) Name of husband or wife..... -			
7. Birth date of deceased (mo., day, yr.)		6.(c) If alive, give age years	
May 16, 1944			
8. AGE:	Years	Months	Days
	2	-	27
			If less than one day
		hrs.min.

9. Birthplace..... Washington, D. C.
(Town, county, and state)

10. Usual occupation..... (child)

11. Industry or business

12. Name **Jack Kerns**

FAT 13. Birthplace Washington, D. C.

14. Maiden name Margaret Barnett

15. Birthplace **Washington, D. C.**

16. Informant: **Jack Kerns, Father**

Address 2515 - 13St. N. W.

17 Removal Date thereof June 12, 1946

(Burial, cremation, or removal. Which?) 7 (month) (day) (year)

Cemetery or crematory..... 1st St. B.C.

Location W Washington, #1

18. Funeral director..... J. A. Adams Co.....

Address 2901 1425 n.w.

19. June 12, 1944 Kowland S. Philips

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 12 1946 at 7:50 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 29, 1946 to June 12, 1946 and that I last saw her alive on June 11, 1946

Immediate cause of death.....
Tuberculous Meningitis.....

DURATION.....
16 da.....

Due to

Acute Miliary Tuberculosis 3 1/2 M

Due to.....

Tuberculous Cervical Adenitis 3/2 M

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Antopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury	Injured at work?
<hr/>	

Daniel R. Pinney, MD

23. SIGNATURE [Signature] M. D. or other [initials]

Address 17 Penn State Rd Date signed 6/12/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 19 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

06188

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 37 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 37 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4106 - Lee St. N. E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war. _____ ✓

3. (a) FULL NAME

KIRKSEY, MELVIN B

3. (b) Social Security Number

-

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife. _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) April 19, 1930
 8. AGE: Years 16 Months 1 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace Washington, D. C.
 (Town, county, and state)
 10. Usual occupation Student
 11. Industry or business _____

FATHER
 12. Name Hugh D. Kirksey
 13. Birthplace Washington, D. C.
MOTHER
 14. Maiden name Catherine Brooks
 15. Birthplace Rectortown, Virginia

16. Informant Decedent
 Address _____
 17. Removal Date thereof June 6, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____
 Location to Washington, D. C.
 18. Funeral director Arthur S. Rollins
 Address 4339 - Hunt Pl. N.E. Wash. D.C.

19. June 6, 1946 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1946 at 2:55 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/30 1946, to 6/6 1946
 and that I last saw him/her alive on 6/6 1946

Immediate cause of death _____ DURATION
tuberculosis 3 days
meningitis
 Due to pulmonary
tuberculosis 1 mo.
 Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Pinucane MD M. D. or other
Glenn Dale Md Date signed 6/6/46
 Address _____

RECEIVED
JUN 19 1946
BUREAU U S

Evidence for the change of age
of deceased is shown on film

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

06189

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George
City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mos. & 17 days
Hospital, institution, or street address where death occurred:
Leland Memorial Hospital
How long in hospital or institution? 4 Mos. & 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md. County Montgomery
City or town Dickerson
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

Thomas Kohlenberg

3. (b) Social Security Number

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Georgia Turner Kohlenberg
- deceased - 6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) February 9, 1872

8. AGE: Years 74 Months NBI Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Frederick Co., Md.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business _____

12. Name William Kohlenberg

13. Birthplace Frederick Co., Md.

14. Maiden name Edlen Traut

15. Birthplace Frederick Co., Md.

16. Informant Hospital Records

Address _____

17. Burial Date thereof 6/20/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery

Location Beallsville, Md.

18. Funeral director W. B. Nelson

Address Barnesville, Md.

19. June 17, 1946 Registrar James Seery
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17, 1946 at 3:40 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 3, 1946 to June 17, 1946
and that I last saw him alive on June 13, 1946

Immediate cause of death Cerebral Hemorrhage

thrombosis DURATION 15 min.

Due to Generalized Arterio-sclerosis 25 yrs.

Due to _____

Other conditions old skull fracture of rt. temporal area - depressed.

(Include pregnancy within 8 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Walcutt W. Gibson, M.D. M. D. or other _____

Address 4404 Queensway Rd. Date signed 6-17-46

Thurmont, Md.

MARGIN RESERVED FOR BINDING

VS A15, 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on film. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 19 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

06190

1. PLACE OF DEATH:

County.....**Pro Geo Co**
 City or town.....**Brentwood Maryland.**
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....**Maryland** County.....**Pro Georges**
 City or town.....**Brentwood Maryland**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....**4405 37th street**
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Lydia Ann Longley

3.(b) Social Security Number

4. Sex.....**female** 5. Color or race.....**white** 6.(a) Single, married, widowed, or divorced.....**married**
 6.(b) Name of husband or wife.....**Harry Longley**
 6.(c) If alive, give age.....**68 yrs** years
 7. Birth date of deceased (mo., day, yr.).....**March 26, 1878**
 8. AGE: Years.....**68** Months..... Days..... If less than one day..... hrs. min.

9. Birthplace.....**Annapolis Maryland**
 (Town, county, and state)

10. Usual occupation.....**Housewife**

11. Industry or business

FATHER 12. Name.....**James B. Taylor**
 13. Birthplace.....**Maryland**

MOTHER 14. Maiden name.....**Hanna E. Tipton**
 15. Birthplace.....**Maryland**

16. Informant.....**Harry Longley**
 Address.....**Maryland**

17. **Cremation** Date thereof.....**June 24, 1946**
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....**Cedar Hill Cemetery**
 Location.....**Suitland Maryland**

18. Funeral director.....**F. Gasch's Sons**
 Address.....**Hyattsville Maryland**

19. **June 22 1946** **James Severy**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

June 20, 1946**3:20P.M.**

20. DATE OF DEATH..... 19.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-2-1945 to **6-20-1946**and that I last saw him alive on **6-20-1946**

Immediate cause of death.....

Multifocal Myeloma

DURATION

1 1/2 yrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....**Int. Registrar** Date signed.....**6-22-46**

00300

RECEIVED

JUN 24 1946

RECEIVED
JUN 24 1946
BUREAU V.E.

Personal

WESLEY L. LIGER

SAC, NEW YORK

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92

CERTIFICATE OF DEATH

06191

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town Mitchellville Del. Air Force
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's
 City or town Mitchellville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Del Air Force
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John Wesley Lowman

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Sadie Ann Lowman7. Birth date of deceased (mo., day, yr.) Jan 6, 1906 6. (c) If alive, give age 40 years8. AGE: Years 80 Months 4 Days 24 If less than one day hrs. min.9. Birthplace Odenton, Prince George's Co. Md.
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Small Farm12. Name Wesley Lowman13. Birthplace P.A. Co. Md. (Shenandoah)14. Maiden name Marion Wade15. Birthplace P.A. Co.16. Informant Sadie Ann LowmanAddress Mitchellville Md17. Buried Date thereof July 2, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Nichols MemorialLocation Odenton Md18. Funeral director Clarence ForeacreAddress Mitchellville Md19. July 1 19 46 Louise H. Peach
Date rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 19 46 at 3:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 28 19 46 to June 29 19 46
 and that I last saw him alive on June 29 19 46

Immediate cause of death

Acute myocardial

DURATION

1 dayDue to Heart congestion4 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Robert J. Lowman

M. D. or other

Address Mitchellville Md Date signed 6/30/46

RECEIVED

AUG 9 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

06192 245
Reg. Dist. No.

1. PLACE OF DEATH:

County 4501-R.I. Ave
City or town Mountwood Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. CountyCity or town BRENTWOOD
(If outside city or town limits, write RURAL and give nearest town)Street No. 4501-R.I. Ave
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

GEORGE W. M. LUCAS

3. (b) Social Security Number

4. Sex M. 5. Color or race C 6. (a) Single, married, widowed, or divorced M.6. (b) Name of husband or wife MATTIE B. LUCAS

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 18738. AGE: Years 73 Months Days If less than one day
hrs. min.9. Birthplace WASHINGTON D.C.
(Town, county, and state)10. Usual occupation CLERGYMAN

11. Industry or business

12. Name MOSES LUCAS13. Birthplace Va.14. Maiden name UNKNOWN

15. Birthplace

16. Informant PEARL M. LOCKHEARTAddress 4501 R.I. Ave.17. Removal Date thereof June 17 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Washington D.C.18. Funeral director W. Ernest Jarvis Co.Address 1432-Yale St. N.W.19. June 17 1946 James Serry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-17 19 46 at 5:10 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
3-29 19 39 to 6-17 19 46and that I last saw him alive on 6-17 19 46Immediate cause of death Coronary Embolism

DURATION

1 HrDue to Hypertension 2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Grant Lucas MD M. D. or otherAddress 1738-15 NW Date signed 6-17-46

SECRET

RECEIVED
JUN 19 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 330

CERTIFICATE OF DEATH

06193

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges
 City or town Marlboro Pike Washington 1980
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 weeks
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr. Geo. Co.
 City or town Washington 1980
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1323 Quaker St NE
 (If rural, give LOCATION Washington DC)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Marion Ferdinand Luttrell

3. (b) Social Security Number

579-16-7079

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Anna Dora M. Parry Luttrell
 7. Birth date of deceased (mo., day, yr.) Feb 1, 1870 6. (c) If alive, give age 75 years
 8. AGE: Years 76 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Summerton, Va.
 (In how many states?) _____
 10. Usual occupation Farmer - Retired
 11. Industry or business owners - Drury's Hotel
 12. Name John T. & a street
 13. Birthplace Virginia
 14. Maiden name Barbara Northern
 15. Birthplace Virginia

16. Informant Mrs. Donna Talsan
 Address 6503-Oakwood Lane 19
 17. Burial Date thereof June 29, 1946
 (Burial, cremation, or removal?) (month) (day) (year)
 Cemetary or crematory Forest Hill

Location Heathsville Md. Bloomsburg Rd. Md.
 18. Funeral director Deal Funeral Home
 Address Washington D.C.

19. 6/27 19 46 Carrie Campbell
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1946 at 4:50 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21, 1946 to June 27, 1946
 and that I last saw him alive on June 26, 1946
 Immediate cause of death Cerebral Hemorrhage DURATION 6 days
 Due to General Arterio Sclerosis Nature
 Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please indicate the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following; no
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Paul C. Van Gatta M. D. or other _____
Washington 1980 Date signed 6/27/46

RECEIVED
JUL 1 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06194

Reg. Dist. No. 245

1. PLACE OF DEATH: Prince Georges
County.....
Riverdale
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
Eugene Leland Memorial Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D. C. County.....
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1021 7th Street, N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME
Mario Manuel Maggio

3.(b) Social Security Number

4. Sex Male
5. Color or race white
6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) June 12, 1946

8. AGE: Years Months Days
2 hrs. min.

9. Birthplace Riverdale, Maryland
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER t2. Name Frank Aloysius Maggio

t3. Birthplace Philadelphia, Pa.

MOTHER t4. Maiden name Maruja Teresa Tama

t5. Birthplace Guayaquil, Ecuador, S. America

16. Informant Mrs. Maruja T. Maggio

Address 1021 7th St., N.E., Wash., D.C.

t7. (Burial, cremation, or removal. Which?) Date thereof 6/17/46
month day year

Cemetery or crematory Mt. Olivet Cemetery

Location Wash. D.C.

18. Funeral director New Chambers Co.

Address Riverdale Rd.

Date rec'd by registrar June 16 46

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1946, at 8:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12, 1946, to June 14, 1946, and that I last saw him alive on June 14, 1946.

Immediate cause of death Atelectasis
DURATION 7 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. W. Malin MD

Address 44404 Queensbury Rd M. D. or other

Date signed 6/14/46

MARGIN RESERVED FOR BINDING

VS A15 9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 19 1946
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-2)

CERTIFICATE OF DEATH

★ 06195 231
Reg. Dist. No.

1. PLACE OF DEATH:

County Prince Georges
City or town Cheverly Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince Georges General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Beltsville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Albert Ashby. Manuel

3. (b) Social Security Number

4. Sex _____ 5. Color or race _____ 6.(a) Single, married, widowed, or divorced _____

Male White Married6.(b) Name of husband or wife Laisy Manuel7. Birth date of deceased (mo., day, yr.) Feb 28, 18808.(c) If alive, give age 64 years

8. AGE: Years _____ Months _____ Days _____ If less than one day _____

66 3 21 _____ hrs. _____ min.9. Birthplace Morrisville Va.
(Town, county, and state)10. Usual occupation Retired

11. Industry or business _____

12. Name Lucian Morgan Manuel13. Birthplace Charlestown, Va.14. Maiden name Laisy Bell15. Birthplace Alexandria, Va.16. Informant Marvin ManuelAddress 3707-43rd Ave. Cottage City17. Burial Date thereof 6/21/46 (month) (day) (year)Cemetery or crematory St John'sLocation Beltsville Md18. Funeral director F. Gascho sonsAddress Syattsville Md19. 6/20 1946 Amanda Lounney Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18th 1946 at 9:45 P M21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 20 1946 to June 18 1946and that I last saw him alive on June 18 1946

Immediate cause of death _____

Cardiac decompensation DURATION 3 weeksDue to Chronic myocarditis 4 yrsDue to Chronic Asthma 4 yrsOther conditions arteriosclerosis 4 yrsFracture of right hip: Due to 3 weeks

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of May 27th, 1946Where did injury occur? Prince Georges General Hospital

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) In HospitalMeans of injury Accidental falls Injured at work?23. SIGNATURE W. Suit P. P. Chue M.D.Address 6406 Ritchie Rd SE Date signed June 19 1946Wash. D.C.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 22 1944

U. S. AIR FORCE

RECEIVED

JUN 22 1944

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age
& birth date of deceased
is shown on

FILM No. I O 7 OCT 18 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06196

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George's
City or town Lanham Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 year
Hospital, institution, or street address where death occurred:
Leesense Highway
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Lanham Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. Leesense Highway
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME

Ivan Van Marsden

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Ivan Van Marsden
6. (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Nov - 1-883 1887

8. AGE: Years 58 Months 62 Days It less than one day
hrs. min.

9. Birthplace New York City, N. Y.
(Town, county, and state)

10. Usual occupation Psychologist

11. Industry or business

12. Name Unknown

13. Birthplace England

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mr. Ivan Van Marsden

Address Leesense Highway, Lanham Park, Md.

17. Burial Date thereof 6/26/76
(Burial, cremation, or removal. Where?) (month) (day) (year)

Cemetery or crematory St. Lucie's Church

Location Wash. D.C.

18. Funeral director Chambers

Address 5801 Cleveland Ave. Bethesda, Md.

19. 6/25 19 46 Amanda Downey
(Date recd by registrar) Registrar

MEDICAL CERTIFICATION

2d. DATE OF DEATH June 23 1946 at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19

and that I last saw him alive on 19

Immediate cause of death

Acute congenital heart failure
Due to Cardiovascular renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

deputy medical examiner

23. SIGNATURE James S. Boyd
M. D. or Other

Address Forestville Md. Date signed 6-23-46

RECEIVED
JUN 26 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

CERTIFICATE OF DEATH

06197
Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
City or town Glenn Dale, Maryland (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mos., 14 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 6 mos., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State D. C.
County Washington
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1404-A Half Street S. W.
(If rural, give LOCATION)
2.(a) If veteran, name war -

3. (a) FULL NAME

Marshall, Arthur N.

3. (b) Social Security Number

4. Sex m
5. Color or race Colored
6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Emma Marshall
6. (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) 11-5-1905
8. AGE: Years 51 Months 1 Days 20
it less than one day hrs. min.

9. Birthplace Washington DC
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Navy Yard

FATHER
12. Name Joseph Marshall
13. Birthplace ?
MOTHER
14. Maiden name Annie ?
15. Birthplace ?

16. Informant Decedent
Address
17. Removal Date thereof 6-13-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory to Wash. DC
Location

18. Funeral director John T. R. Jones & Co.
Address 901-3rd St. S. W.

19. June 13, 1946 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1946 at 2:50 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-30 1945, to 6-13 1946.

and that I last saw him alive on 1946.

Immediate cause of death Pulmonary Tuberculosis
far advanced DURATION 22 mo.

Due to Tuberculous Saryngitis 6 mo.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel Leo Finicane MD
M. D. or other
Address Glenn Dale MD Date signed 6/13/46

RECEIVED
JUN 19 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1654

CERTIFICATE OF DEATH

06205

Reg. Dist. No. 245

1. PLACE OF DEATH:

County... Prince Georges
 City or town... Rogers Heights
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 14 years
 Hospital, institution, or street address where death occurred
 5004 - 53rd Place
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Prince Georges
 City or town... Rogers Heights
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 5004 - 53rd Place
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3.(a) FULL NAME

Lillian Dorothy Masanovsky

3.(b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Morton Masanovsky
 6.(c) If alive, give age 45 years
 7. Birth date of deceased (mo., day, yr.) April 21, 1908
 8. AGE: Years 38 Months 1 Days 28 If less than one day hrs. min.

9. Birthplace Baltimore Md (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Iron Working
 12. Name John William
 13. Birthplace Baltimore Md
 14. Maiden name Elizabeth
 15. Birthplace Baltimore Md

16. Informant Morton Masanovsky
 Address 5004 - 53rd Place Rogers Heights, Md
 17. Burial (Burial, cremation, or removal, Which?) June 12, 1946 (Date thereof) (month) (day) (year)
 Cemetery or crematory Mt. Olivet Cemetery
 Location Baltimore Md

18. Funeral director F. S. Sacks sons
 Address Hyattsville Md

19. June 12, 1946 (Date rec'd by registrar) James Derry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 1946 at 4:30 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19... to 19... and that I last saw him alive on 19...

Immediate cause of death Asphyxia
 Due to Acute Carbon Monoxide Poisoning
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations... Date of op...
 Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of... 6-11-46
 Where did injury occur? Rogers Heights P.G. Md (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) Yes
 Means of injury... injured at work? No
 23. SIGNATURE James Derry M. D. of others
 Address Freshwater Date signed 6-11-46

RECEIVED
JUN 14 1946
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 243

CERTIFICATE OF DEATH

06198

Reg. Dist. No. 243

1. PLACE OF DEATH:

County... Prince George's

City or town... Mitchellville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Prince George's

City or town... Mitchellville
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Carroll Marvin Marshall

3. (b) Social Security Number

4. Sex

male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 1, 1938

8. AGE:

Years

Months

Days

It less than one day

8

2

3

hrs. min.

9. Birthplace

Washington DC
(Town, county, and state)

10. Usual occupation

house

11. Industry or business

MOTHER FATHER

12. Name

Curtis S. Marshall

13. Birthplace

Maryland

14. Maiden name

Nettie Hawkins

15. Birthplace

Maryland

16. Informant

Address

Curtis S. Marshall

17.

(Burial, cremation, or removal, which?)

Date thereof

June 6, 1946
(month) (day) (year)

Cemetery or crematory

Holy Family

Location

Mitchellville and

18. Funeral director

Address

Clarence Foreacre

Mitchellville and

19.

(Date rec'd by registrar)

19 46

Mrs J. W. Hughes
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 3, 1946, at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him alive on 19...

Immediate cause of death

acute inanition

DURATION

Due to

Due to

Other conditions

child was premature
poorly developed
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James F. C. [Signature]
Address... Annapolis, Md. Date signed 6-4-46

RECEIVED

JUN 11 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1212

CERTIFICATE OF DEATH

06199

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince Georges

City or town University Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

4310 Clazett Road.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town University Park
(If outside city or town limits, write RURAL and give nearest town)Street No. 4310 Clazett Road
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Adelia Estelle Mathewson

3. (b) Social Security Number

579-07-0049

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 26, 1874

8. AGE:

Years 72 Months 1 Days 17 If less than one day hrs. min.

9. Birthplace

New York
(Town, county, and state)

10. Usual occupation

Book keeper

11. Industry or business

12. Name William A. Mathewson

13. Birthplace

New York

14. Maiden name

15. Birthplace

16. Informant

Mrs. Regina J. Besley

Address 4310 Clazett Road, University Park

transportation
(Burial, cremation, or removal. Which?)Date thereof June 15, 1946
(month) (day) (year)

Cemetery or crematory

Oneida

Location

new York

18. Funeral director

F. Busch's sons

Address

Hyattsville Md.

19. June 15, 1946 James Serw
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1946 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

Acute pulmonary
edema
Due to Acute congestive heart
failure
Due to Cardiovascular renal
disease

Other conditions

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Report medical examiner

23. SIGNATURE James S. Serw

M.D. or other

Address Freshwater Date signed 6-13-46

00100

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED
JUN 19 1946
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06200

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George's

City or town Baltimore Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos

Hospital, institution, or street address where death occurred

Mother Jones (St) Home

How long in hospital or institution? 2 mos

City or town Baltimore Md

3. (a) FULL NAME

Archibald Robert M^cCallum Sr.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Montgomery

City or town Silver Spring Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 803 Briggs Ave

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Sarah Littleton McCallum

7. Birth date of

deceased (mo., day, yr.)

Sept 26, 1873

6. (c) If alive, give age

years

8. AGE:

Years 72 Months Days If less than one day

hrs. min.

9. Birthplace

Glen Ridge (Town, county, and state)

10. Usual occupation

Railway mail clerk

11. Industry or business

Retired

12. Name

Daniel M^cCallum

13. Birthplace

Scotland

14. Maiden name

Ann Marie Pollock

15. Birthplace

Scotland

16. Informant

A. Robert M^cCallum Jr.

Address 7805 Boston Ave NE Spg Md.

Bureau

Date thereof June 15, 1946

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Rock Creek

Location Washington DC

18. Funeral director Deal Funeral Home

Address 4812 Ga Ave NW Wash DC

June 13 1946 James Severy

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1946 at 2:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 20 1946 to June 13 1946

and that I last saw him alive on June 12 1946

Immediate cause of death

Chorea Uremia

DURATION

1/22/46

Due to

Chorea Uremia

Due to

not acute sufficing 4/18/46

Other conditions

(include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Howard T. Moore Jr.

Address 7805 Ave Takoma Park Md 6/12/46

Date signed

RECEIVED
JUN 15 1946
BUREAU OF

RECEIVED

JUN 11 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06202

Reg. Diat. No. 231

1. PLACE OF DEATH:

County Prince GeorgesCity or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince Georges General HospitalHow long in hospital or institution? 2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Prince GeorgesCity or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 5401 - 39th Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Wallace Warren Millard

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Margaret Millard

7. Birth data of

deceased (mo., day, yr.)

April 27, 19188. (c) If alive, give age 27 years

8. AGE:

Years

Months

Days

If less than one day

28123

hrs.

min.

9. Birthplace

Maine New York, Broome Co.
(Town, county and state)

10. Usual occupation

Machinist - Foreman

11. Industry or business

Industry

FATHER

12. Name

Alfred Forest Millard

13. Birthplace

Greensfield, Pa

14. Maiden name

Lela Warren

15. Birthplace

Clifford, Pa

16. Informant

Harry Millard

Address

6624 - Wells Parkway, Riverdale

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

6/27/46

Cemetery or crematory

St. Luke's Church

Location

Wagoner

18. Funeral director

W.W. Chambers, Co

Address

Riverdale, Md.

19.

Date rec'd by registrar

June 22, 1946

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19, 1946 at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw h

alive on

19

Immediate cause of death

Remarriage and shock
gun shot wound
of head

DURATION

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 6-19-46Where did injury occur? Hyattsville, Pa.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury shot with north with injured at homeReputable medical examiner

23. SIGNATURE

James J. ...
M. D. or otherAddress Forest Hill Date signed 6-19-46

RECEIVED
JUN 24 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 191-04

CERTIFICATE OF DEATH

★06203 239

Reg. Dist. No.

1. PLACE OF DEATH:

County.....*Laurel Maryland*.....
 City or town.....*Laurel*.....
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....*465 days*.....
 Hospital, institution, or street address where death occurred:
Home.....

How long in hospital or institution?.....*X*.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*MD*..... County.....*Pr Geo*.....

City or town.....*Laurel*.....
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....*Main St*.....
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Joseph William Harrison

3. (b) Social Security Number

4. Sex.....*Male*.....

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....*2/19/78*.....

6.(c) If alive, give age..... years

8. AGE: Years.....*68*..... Months.....*4*..... Days.....*1*.....
 If less than one day..... hrs..... min.....

9. Birthplace.....*Harvard County Md*.....
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name.....*Harold William Harrison*.....

13. Birthplace.....*Harford County Maryland*.....

MOTHER 14. Maiden name.....*Miss Elizabeth Paul*.....

15. Birthplace.....*Harford County Maryland*.....

16. Informant.....*Miss Fannie Harrison*.....

Address.....*500 Main St, Laurel Md*.....

17. Burial Date thereof.....*June 21-1946*.....
 (Burial, cremation, or removal. Which?)..... (month) (day) (year)

Cemetery or crematory.....*Trinity Hill*.....

Location.....*Laurel Md*.....

18. Funeral director.....*The C. White Co*.....

Address.....*Laurel Md*.....

19. Date rec'd by registrar.....*June 21 46*.....

Registrar.....*Geo E. Wachtler*.....

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*June 19 1946*..... at.....*4:45 P.M.*.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....*3/8*.....
 and that I last saw him alive on.....*2-19*.....

Immediate cause of death.....*Pulmonary edema*.....

DURATION

Due to.....*Chronic Induced*.....

Due to.....*asphyxia*.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....*D. B. Harrison*.....

Address.....*Laurel*.....

Date signed.....*6/21/46*.....

RECEIVED

RECEIVED

RECEIVED
JUN 25 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

06204

230

1. PLACE OF DEATH:

County PRINCE GEORGECity or town AMANDALE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENNA County MONTGOMERYCity or town NORRISTOWN
(If outside city or town limits, write RURAL and give nearest town)Street No. 1346 HARDING BLVD.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

IRENE MORROW

3. (b) Social Security Number

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

SINGLE

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 17 1900

6. (c) If alive, give age years

8. AGE:

46 Years3 Months13 Days

If less than one day

hrs. min.9. Birthplace Philadelphia Penna
(Town, county, and state)10. Usual occupation Saleswoman

11. Industry or business

millinery

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant NORMAN MARLOWEAddress 4 E. GRANVILLE DRIVE S.S. MD17. Transportation 7-1-46
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. July 1st
(Date rec'd by registrar)19. 46John D. Smith
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1946 at 7:40p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death Compound comminuted fracture of skull -
Auto-accident on public highway. Route 1

Due to

Other conditions Crushed chest - comp. comminuted fracture left humerus
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of June 30, 1946Where did injury occur? Amandale Pa. Grad. Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public Place - Rt. 1Means of injury Auto accident Injured at work?23. SIGNATURE John D. Maloney, M.D. a ting deep
M. D. or other med. exam.Address Hyattsville, Md Date signed 7-1-46

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JUL 3 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 132

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
City or town (Rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mos., 17 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 6 mos., 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State D. C. County _____
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1219 G. Street N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

JESSIE MAE PENDARVIS

3. (b) Social Security Number

?

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife _____
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) September 28, 1927
8. AGE: Years 18 Months 9 Days - It less than one day _____ hrs. _____ min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual occupation Cafeteria Employee
11. Industry or business Government
12. Name Kanie Pendarvis
13. Birthplace South Carolina
14. Maiden name Ellen ?
15. Birthplace South Carolina

16. Informant Decedent
Address _____

17. Removal Date thereof June 28, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory _____
Location to Washington, D.C.

18. Funeral director Henry J. Washington & Son
Address 467 N. St. N.W.

19. June 28, 1946 Rowland S. Philips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28th 19 46 at 4:55 M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 11th 19 45 to June 28th 19 46
and that I last saw her alive on June 28th 19 46

Immediate cause of death _____ DURATION 8 mos
Pulmonary Tuberculosis
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

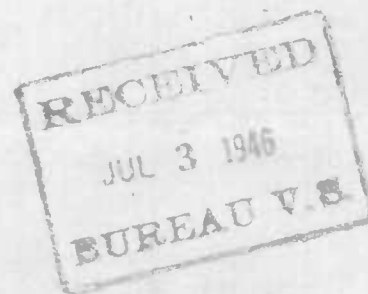
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Finucane M.D.
M. D. or other _____
Address Glenn Dale, Md. Date signed 6/28/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06207

Reg. Dist. No.

245

1. PLACE OF DEATH:

County Prince George'sCity or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Transient

Hospital, institution, or street address where death occurred:

Leland Memorial HospitalHow long in hospital or institution? Dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Tuxedo
(If outside city or town limits, write RURAL and give nearest town)Street No. 5802 Arbor
(If rural, give LOCATION)2.(a) If veteran, name war World War 11

3. (a) FULL NAME

Leonard F. Reel

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

April 13, 1922

8. AGE:

Years
24

Months

Days

If less than one day

..... hrs. min.

9. Birthplace Washington, D.C.
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

FATHER
MOTHER12. Name Fulton L. Reel13. Birthplace Washington, D.C.14. Maiden name Melvina Yonder15. Birthplace Hungary16. Informant Fulton L. ReelAddress Tuxedo, Md.17. Burial Date thereof June 8, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar Hill CemeteryLocation Suitland Maryland18. Funeral director F. Gasch's Sons

Address

Hyattsville Maryland.19. June 7
(Date rec'd by registrar)

19

J. J. Perry

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 19 46 at 12:35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to 19.....

and that I last saw him alive on 19.....

Immediate cause of death

Myocardial infarctionDue to Crushed abdomen, pelvisand chestDue to Fracture left arm

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6/6/46Where did injury occur? Riverdale P. G. Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Route # 1Means of injury Pedestrian struck by a car

Deputy Medical Examiner

23. SIGNATURE James P. Perry M.D. or otherAddress Forest Hill Date signed 6-6-46

RECEIVED
JUN 11 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (91-2)

CERTIFICATE OF DEATH

06208

Reg. Dist. No. 234

1. PLACE OF DEATH:

County Prince George'sCity or town Piscataway
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Piscataway
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Joseph Mary Ritmiller

3. (b) Social Security Number

4. Sex male5. Color or race White6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Elbia Bridgett6. (c) If alive, give age 72 years7. Birth date of deceased (mo., day, yr.) May 2, 18778. AGE: Years 69 Months 7 Days 27 If less than one day _____ hrs. _____ min.9. Birthplace Baltimore, Md
(Town, county, and state)10. Usual occupation Concrete worker11. Industry or business Construction12. Name George Ritmiller13. Birthplace Germany14. Maiden name Rosina Funk15. Birthplace Germany16. Informant Harold A. ReedAddress Piscataway, Md17. Burial Date thereof June 10, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory New Cathedral CemLocation Baltimore, Md10. Funeral director Howard StrongAddress 3207 1/2 North Ave. Balts. Md19. June 6, 1946 Mrs. Alton Davis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1946 at 2:40 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22, 1946 to June 6, 1946and that I last saw him alive on May 27, 1946Immediate cause of death congestive heart failure

DURATION

Due to cardiovascular renal disease

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

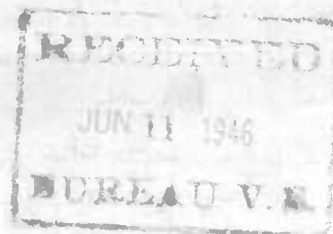
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James T. Boyd M.P. or otherAddress Piscataway, Md Date signed 6-6-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

06209

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
D. C.
 State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6025 Sheriff Rd. N. E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Rowe, Emmalee

3. (b) Social Security Number

?

4. Sex

F

5. Color or race

C

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Rayman Rowe

7. Birth date of deceased (mo., day, yr.)

10-1-1922

6. (c) If alive, give age _____ years

22

8. AGE:

Years

Months

Days

If less than one day

23825

hrs.

min.

9. Birthplace

Leesville, South Carolina
(Town, county, and state)

10. Usual occupation

Chambermaid

11. Industry or business

Hotel

FATHER

12. Name

Yancy Bobo

13. Birthplace

Leesville, South Carolina

MOTHER

14. Maiden name

Sally Jones

15. Birthplace

Suldie, South Carolina

16. Informant

Sally Bobo - Mother

Address

6025 Sheriff Rd. N. E.

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

June 27, 1946
(month) (day) (year)

Cemetery or crematory

Location

to Washington, D. C.

18. Funeral director

Arthur L. Rollins

Address

4339 Hunt Pl. N.E.

19. June 26, 1946

Rowland S. Phillips

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

6-2619. 46, at 925 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 11, 1946, to June 26, 1946

and that I last saw him alive on

June 26, 1946

Immediate cause of death PULMONARY
TUBERCULOSIS FAR
ADVANCED

DURATION

2 mo?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Daniel Leo Pinucane M.D.

M. D. or other

Address

Glenn Dale, Md.

Date signed

6/26/46

RECEIVED

JUL 3 1946

BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 60

CERTIFICATE OF DEATH

06210

Reg. Dist. No. 245

1. PLACE OF DEATH:

County..... Prince Georges
 City or town..... Riverdale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 15 Hours.
 Hospital, institution, or street address where death occurred:
Ieland Memorial Hospital
 How long in hospital or institution?..... 15 Hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Prince Georges
 City or town..... Greenbelt
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 13 B Hillside Road
 (If rural, give LOCATION)
 2. (a) If veteran, name war..... -

3. (a) FULL NAME

Pauline M. Ruback

3. (b) Social Security Number

-

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married8. (b) Name of husband or wife..... Stephen Ruback

B. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) January 1, 19068. AGE: Years Months Days If less than one day
40 6 8 hrs. min.9. Birthplace..... Pennsylvania
 (Town, county, and state)10. Usual occupation..... Hswf.11. Industry or business..... Own Home12. Name..... Joseph Hodek13. Birthplace..... Czechoslovakia14. Maiden name..... Theresa Vittek15. Birthplace..... Czechoslovakia16. Informant..... Mr. Stephen RubackAddress..... 13 B Hillside Road, Greenbelt, Md.17. Burial Date thereof..... 6/9/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Louisford PaLocation..... WW. Chambers Co18. Funeral director..... W.W. Chambers CoAddress..... Brown Dale, Md.19. June 9, 1946 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 9, 19 46 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 19, 45, to June 9, 46
 and that I last saw him alive on June 8, 1946Immediate cause of death..... Carcinoma of Breast, 5 cm.with metastases to
secondary and metas.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Amputation of Breast 4.5
 Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... L. D. Mader, M.D. M. D. or otherAddress..... Riverdale, Md. Date signed..... 6-9-46

RECEIVED

JUN 11 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

06211

Reg. Dist. No. 234

1. PLACE OF DEATH:

County Prince Georges
 City or town Oxon Hill Washington 2000
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 26 yrs
 Hospital, institution, or street address where death occurred: —
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince Georges
 City or town Washington 2000
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5701-Wheeler Rd
 (If rural, give LOCATION)
 2.(a) If veteran, name war NO

3. (a) FULL NAME

Albert Ruben Sandy

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 8.(b) Name of husband or wife Allice Sandy
Deceased 8.(c) If alive, give age — years
 7. Birth date of deceased (mo., day, yr.) Aug 27 1869
 8. AGE: Years 76 Months — Days — If less than one day — hrs. — min.

9. Birthplace Chesapeake Co Maryland
 (Town, county, and state)

10. Usual occupation Retired - Engineer

11. Industry or business St Elie Hospital

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Mary Jane Baxter

15. Birthplace Ches. Co. Md.

16. Informant Edith Rafter

Address 5701 Wheeler Rd. Washington 2000

17. Burial Date thereof Jan 4 - 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St Barnabas Cemetery

Location Oxon Hill Maryland

18. Funeral director Thomas S. Murray

Address 2007 Nicholson St. N.W. DC

19. June 2 19 46 Howard J Ball
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1946 at 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to June 2 1946 and that I last saw him alive on June 1 1946

Immediate cause of death Acute Coronary Thrombosis

Due to General Arteriosclerosis

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
 Accident, suicide, or homicide Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul C. Van Yatta M.D. June 2 1946
 Address Washington 1900 Date signed June 2 1946

RECEIVED
JUN 6 1946
BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

06212

Reg. Dist. No.

242

1. PLACE OF DEATH:

County Pro. Geo. Co.City or town Ritchie Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State M. D. County Pr. Geo.City or town Ritchie
(If outside city or town limits, write RURAL and give nearest town)Street No. Pr. Geo. County Chambers
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Edward Schlosser

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Grace E. Schlosser

7. Birth date of deceased (mo., day, yr.)

April 5, 1890.

6. (c) If alive, give age years

8. AGE:

56

Years

Months

1

Days

29

If less than one day

hrs.

min.

9. Birthplace

Washington D. C.

(Town, county, and state)

10. Usual occupation

Carpenter & builder-

11. Industry or business

FATHER
MOTHER

12. Name

John Schlosser

13. Birthplace

Washington D. C.

14. Maiden name

Unknown

15. Birthplace

Washington D. C.

16. Informant

Grace Dowell (daughter)

Address

Gordonsville Virginia

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

June 7, 1946
(month) (day) (year)

Cemetery or crematory

Evergreen Cemetery

Location

Bladensburg Maryland

18. Funeral director

F. Gasch's Sons

Address

Hyattsville Maryland.

19.

(Date rec'd by registrar)

19

Thos D. Gifford
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4, 1946 19..... at 12 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1941, to June 4, 1946and that I last saw him alive on May 26, 1946

Immediate cause of death

Coronary thrombosis

DURATION

2 hr

Due to

Arteriosclerosis7 years?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John J. Maloney MD
Address Chesley, Md Date signed 6-5-46

RECEIVED
JUN 8 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0621243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 mos., 27 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 8 mos., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1736 Willard St. N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____ ✓

3. (a) FULL NAME

SELDEN, CLEMENT A.

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Carroll Selden

7. Birth date of deceased (mo., day, yr.) March 1, 1913 6. (c) If alive, give age 31 years

8. AGE: Years 33 Months 3 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Bedford, Virginia
 (Town, county, and state)

10. Usual occupation Cook

11. Industry or business _____

12. Name Clement A. Selden

13. Birthplace Bedford, Virginia

14. Maiden name Gladden Henry

15. Birthplace Bedford, Virginia

16. Informant Decedent

Address _____

17. Removal Date thereof 5-2-46
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Removal to

Location Washington, D. C.

18. Funeral director W. B. Smith & Son, Inc.

Address 1432 4th St. N.W. Wash. D.C.

19. June 2, 1946 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1946 at 11:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 4 1945 to June 2 1946
 and that I last saw him alive on June 2 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 15 mths.

Due to _____

Due to _____

Other conditions Late latent Syphilis 5 years

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Pinecone MD. M. D. or other _____
Glenn Dale Md. Date signed 6/2/46

Address _____

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 11 1946

BUREAU V F

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06214

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 months
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 10 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1341 - L. Street N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____ ✓

3. (a) FULL NAME

SORRELLS, ELSIE

3. (b) Social Security Number

229-14-4352

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife _____
 5.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) August 2, 1921
 8. AGE: Years 24 Months 10 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Eagle Rock, Virginia
 (Town, county, and state)
 10. Usual occupation Clerk (Store)
 11. Industry or business _____

FATHER
 12. Name James P. Sorrells
 13. Birthplace Eagle Rock, Virginia
 MOTHER
 14. Maiden name Bessie H. Dudley
 15. Birthplace Eagle Rock, Virginia

16. Informant Decedent
 Address _____
 17. Removal to Date thereof June 24, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____
 Location Eagle Rock, Va
 18. Funeral director Bygdon - Reynolds
 Address Eagle Rock, Va
 19. June 23, 1946 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23, 1946 at 2:25 p. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 24 1945 to June 23 1946
 and that I last saw her alive on June 23 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 6 yrs.
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Pinucane M.D. M. D. or other _____
 Address Glenn Dale, Md. Date signed 6/23/46

RECEIVED
JUL 3 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

06215

Reg. Dist. No. 342

1. PLACE OF DEATH

County Prince Geo. Co.City or town Maryland Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Maryland Park
(If outside city or town limits, write RURAL and give nearest town)Street No. 412-65 St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Edwin Mason Steele

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Wid.

8. (b) Name of husband or wife

Bell Steele

7. Birth date of deceased (mo., day, yr.)

2-4-1869

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

77

hrs.

min.

9. Birthplace

Washington; D.C.
(Town, county, and state)

10. Usual occupation

Bricklayer

11. Industry or business

FATHER
MOTHER

12. Name

Thomas Steele

13. Birthplace

Wash; D.C.

14. Maiden name

Eliza Gihlis

15. Birthplace

Wash; D.C.

16. Informant

Mrs Ethel E. Gihlis

Address

412-65 St. Md. Park, Md.17. Cremation

(Burial, cremation, or removal. Which?)

Date thereof

6-13-46

(month) (day) (year)

Cemetery or crematory

Leis Funeral Home

Location

Washington; D.C.

18. Funeral director

J. William Leis, Sr.

Address

380-4 St. N.E.19. 6/13

(Date rec'd by registrar)

19 46Carrie Campbell

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 19 46 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 27 19 46 to June 12 19 46and that I last saw him alive on June 11 19 46

Immediate cause of death

Myocardial infarctionParalysis left side of bodyDue to General arteriosclerosisarteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Paul C. Van DykeAddress Washington 1908 Date signed June 13 1946

RECEIVED
JUN 15 1946
BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 mos., 9 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 9 mos., 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 120 Massachusetts Ave. N. W.
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____ ✓

3. (a) FULL NAME

THOMAS STOWERS

3. (b) Social Security Number

578-59-6269

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married (sep.)
 6. (b) Name of husband or wife Mary Holmes
 7. Birth date of deceased (mo., day, yr.) September 3, 1906 6. (c) If alive, give age _____ years
 8. AGE: Years 39 Months 8 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Anderson, South Carolina
 (Town, county, and state)
 10. Usual occupation Truck Driver
 11. Industry or business _____

FATHER 12. Name Wally Stowers
 13. Birthplace South Carolina
 MOTHER 14. Maiden name Annie Rackett
 15. Birthplace Anderson, South Carolina

16. Informant Decedent
 Address _____
 17. Removal Date thereof June 2, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____
 Location to Washington, D. C.
 18. Funeral director St. Joseph's Funeral Home
 Address 306 G Street, N. W.

19. June 1, 1946 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 1 19 46 at 5-58 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AUG 23 19 45 to JUNE 1 19 46
 and that I last saw him alive on JUNE 1 19 46

Immediate cause of death PULMONARY TUBERCULOSIS DURATION 10 mos

Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Finucane MD M. D. or other _____
Glenn Dale, Md. Address _____ Date signed 6/1/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 11 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

06217

Reg. Dist. No. 242

1. PLACE OF DEATH:

County... Prince George

City or town... Silver Hill
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5-yr

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Prince George

City or town... Silver Hill
(If outside city or town limits, write RURAL and give nearest town)Street No. 20 COLE BROOK DRIVE S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

LOUISE YOUNG STRICKLAND

3.(b) Social Security Number

4. Sex F 5. Color or race white 6.(a) Single, married, widowed, or divorced MARRIED

6.(b) Name of husband or wife ELMORE-M-STRICKLAND

6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) FEB-17-1889

8. AGE: Years 56 Months Days If less than one day hrs. min.

9. Birthplace FII
(Town, county, and state)

10. Usual occupation HOUSE WIFE

11. Industry or business

12. Name Robert W. Young.

13. Birthplace ENGLAND

14. Maiden name ALICE

15. Birthplace TENN

16. Informant ELMORE STRICKLAND

Address 20-Colebrook-Drive S.E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 14, 1946
(month) (day) (year)

Cemetery or crematory CEDER HILL

Location Suitland Maryland.

18. Funeral director W. W. Chambers & Co.

Address 517th St. S.E.

19. 6/12 1946 Carrie F. Campbell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1946 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1946 to June 12 1946 and that I last saw him alive on 5:30 am June 12 1946

Immediate cause of death

General arteriosclerosis; duration unknown
Chronic myocarditis

Due to Bronchial asthma

Due to Coronary thrombosis and myocardial failure; about 24 hours duration

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Andrew Anders

M. D. or other

Address 4671 Home Ave Date signed 6/24/46

Anneland

RECEIVED
JUN 13 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★06218

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George'sCity or town Mitchellville (Rural)
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Prince George'sCity or town Mitchellville (Rural)
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Catherine Thomas

3. (b) Social Security Number

4. Sex Female 5. Color or race Black 6.(a) Single, married, widowed, or divorced MarriedB.(b) Name of husband or wife James Thomas7. Birth date of deceased (mo., day, yr.) April 5 18996.(c) If alive, give age 50 years8. AGE: Years 47 Months 2 Days 4 If less than one day _____ hrs. _____ min.8. Birthplace On George's Is. Md.
(Town, county, and state)10. Usual occupation Homemaker11. Industry or business Own home12. Name Daniel Walker13. Birthplace Virginia14. Maiden name Louise Sky15. Birthplace Virginia16. Informant James ThomasAddress Mitchellville Md.17. Buried Date thereof June 12 1946
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory White MarshLocation Collington Md18. Funeral director Clarence ForeacreAddress Mitchellville Md19. 6-11 19 46 Louise H. Peach
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 19 46 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 12 19 46 to June 9 19 46
and that I last saw him alive on June 9 19 46

Immediate cause of death

Cerebral Myocarditis

DURATION

4 yrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Robert S. McInerney JrAddress Laurel Md Date signed 6/9/46

RECEIVED
JUL 9 1946
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1379

CERTIFICATE OF DEATH

46219

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince GeorgesCity or town Chesley, md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince Georges General HospitalHow long in hospital or institution? 1 1/2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Prince GeorgesCity or town Laurel R 7 10 #1
(If outside city or town limits, write RURAL and give nearest town)Street No. Brooklyn Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Grace Thomason

3. (b) Social Security Number

4. Sex

Female

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Sidney Thomason

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 10, 1884

8. AGE:

Years

Months

Days

If less than one day

62019hrs.min.

9. Birthplace

Baltimore, md.
(Town, county, and state)

10. Usual occupation

N.W.

11. Industry or business

N.W.

MOTHER FATHER

12. Name

William Owens

13. Birthplace

md.

14. Maiden name

Ida Owens

15. Birthplace

md.

16. Informant

Address

Emma Splyman
Laurel, Md.
Burial

17. (Burial, cremation, or removal. Which?)

Date thereof

July 9, 1946
(month) (day) (year)

Cemetery or crematory

Location of

18. Funeral director

Address

19. 6/30 1946
(Date rec'd by registrar)Amanda Downey
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1946, at 10 20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 28 1946, to June 30 1946
and that I last saw him alive on June 29 1946

Immediate cause of death

Chronic nephritis

Due to

Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Manner of injury

Injured at work?

23. SIGNATURE

James F. Tarsner
Upper Marlboro, Md.
Address Date signed 6-30-46

RECEIVED

JUL 2 1946

BUREAU V.A.

ADJUTANT GENERAL'S OFFICE
WASHINGTON, D.C.
JUL 2 1946
RECEIVED
BUREAU V.A.
ADJUTANT GENERAL'S OFFICE
WASHINGTON, D.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

06220

CERTIFICATE OF DEATH



Reg. Dist. No. 231

1. PLACE OF DEATH:

County... Prince Georges

City or town... Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

Prince Georges General Hospital

How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Prince Georges

City or town... Laurel
(If outside city or town limits, write RURAL and give nearest town)Street No... Brooklyn Bridge Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

Sharpe, Mary

3. (b) Social Security Number

4. Sex... F

5. Color or race... W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife... Mr. Sharpe

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1885

8. AGE: Years 60 Months 5 Days 19 It less than one day
hrs. min.9. Birthplace... Md.
(Town, county, and state)

10. Usual occupation... House wife

11. Industry or business

12. Name... Mrs. Ida E. Owens

13. Birthplace... Maryland

14. Maiden name... Ida E. Owens

15. Birthplace... Maryland

16. Informant... Mrs. Emma Seligman

Address... Brooklyn Bridge Rd. Laurel Md.

17. Burial, cremation, or removal, Which? Burial

Date thereof June 12-46 (month) (day) (year)

Cemetery or crematory... St. Paul Hall

Location... Laurel Md.

18. Funeral director... We Hitt Donelson

Address... Laurel Md.

19. Date rec'd by registrar June 12 46

Registrar... Amanda Downey

MEDICAL CERTIFICATION

20. DATE OF DEATH... 6/10 1946 at 6:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-4 1946 to 6-10 1946

and that I last saw him alive on 6-10 1946

Immediate cause of death

Chronic Intestinal

DURATION

?

Due to... Infection

Due to...

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations...

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... N. B. Pennington

Address... Laurel Md.

Date signed... 6/10/46

RECEIVED
JUN 15 1946
BUREAU V.S.

06221

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges
 City or town Oxon Hill-Washington 2000
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr. Georges
 City or town Oxon Hill-Washington 2000
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6051 St Barnabas Road
 (If rural, give LOCATION)
 2. (a) If veteran, name war no

3. (a) FULL NAME

Basil Ignatius Tillman

3. (b) Social Security Number

none

4. Sex m 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married
 8. (b) Name of husband or wife Louise Mathews Tillman
 7. Birth date of deceased (mo., day, yr.) Oct 7 1866 6. (c) If alive, give age 69 years
 8. AGE: Years 79 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Prince Geo. Co Maryland
 (Town, county, and state)

10. Usual occupation Retired - laborer

11. Industry or business at home

12. Name Ignatius Tillman

13. Birthplace Maryland

14. Maiden name Mary Speaks

15. Birthplace Maryland

16. Informant Louise M. Tillman

Address 6051 St Barnabas Rd. DC 20

17. Burial Date thereof 7/3/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oxon Hill Cemetery

Location Oxon Hill, Md

18. Funeral director John P. King & Co

Address 701 - 3rd St. S.W.

19. July 1 19. 46 Thos S. Giffels
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 19. 46, at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19. 46, to June 29 19. 46

and that I last saw him alive on June 29 19. 46

Immediate cause of death Cerebral Hemorrhage DURATION 2 weeks

and Pulmonary Left S. Infarct

Due to General arterio sclerosis hypertension

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. none

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Paul C. Van Vleet M. D. cr
Washington 19 DC Date signed June 29 19. 46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 11 1946
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

06222

Reg. Dist. No. 242

1. PLACE OF DEATH:
 County..... Prince Georges
 City or town..... Chapel Oaks
 (If outside city or town limits, write RURAL and give nearest town)
Newbarn
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
5707 Name St.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Prince Georges
 City or town..... Chapel Oaks
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5707 Name St.
 (If rural, give LOCATION)
 2.(a) If veteran, name War.....

3. (a) FULL NAME
(Baby) Tolson

3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... Negro 6. (a) Single, married, widowed, or divorced.....
 6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... Newbarn (6-19-46)
 8. AGE: Years..... Months..... Days..... If less than one day.....
Newbarn..... 1..... hrs. 5..... min.
 9. Birthplace..... Chapel Oaks, Prince Georges, Md.
 (Town, county, and state)

10. Usual occupation.....
 11. Industry or business.....

FATHER 12. Name..... Edward Sylvester Tolson Sr.
 13. Birthplace..... Washington, D.C.

MOTHER 14. Maiden name..... Grace K. Harrison
 15. Birthplace..... Fairmount Heights, Md.

16. Informant..... Mrs. Grace K. Tolson
 Address..... 5707 Name St.

17. Removal Date thereof..... June 20 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....
 Location..... Washington D.C.

18. Funeral director..... B. Johnson
 Address..... Annapolis Md.

19. 6/20 19 46 Carrie F. Campbell
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 19 1946 at 5:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 19 1946 to June 19 1946
 and that I last saw him alive on June 19 1946

Immediate cause of death..... Prematurity
+ Head Injury in Utero

Due to..... Possible Fall of Mother
or Polyhydramnios

Due to.....

Other conditions..... Hydrocephalus
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE..... John W. Robinson, M.D.
 M. D. or other.....
 Address..... 1601 Eastern Ave. N.E. Date signed..... 6/19/46

53300

ATTENTION: READING ROOM

RECEIVED
JUN 25 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06223

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George
City or town Reverdale
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Deland Memorial Hosp.
Stay in hospital or inst. (yrs., or mos., or days) 12 hours 10 min.
Stay in this community (yrs., or mos., or days) 13 hrs 10 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince George
City or town West Pleasant Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 6902 B. St.
(If rural give LOCATION)
2(d) IF VETERAN, NAME WAR

3. (a) FULL NAME

Mr. Horace Aloysius Walls

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

B (b) Name of husband or wife Mrs. Mary Rebecca Wells

6. (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Sept. 26 1878

8. AGE: Years 67 Months 8 Days 26 If less than one day hrs. min.

9. Birthplace Upper Marlboro, Md.
(Town, county, and state)

10. Usual occupation Farmer (retired)

11. Industry or business Own business

12. Name Joseph Wells

13. Birthplace Prince Georges County, Md.

14. Maiden name Willie Ann Day

15. Birthplace Anne Arundel County, Md.

16. Informant Mrs. Mary Wells (wife)

Address West Pleasant, Md.

17. Burial Date thereof 6 20 46
(Burial, cremation, or removal (which?)) (month) (day) (year)

Cemetery or crematory Episcopal

Location Forestville Md

18. Funeral director Witcher Bros

Address Upper Marlboro Md

19. June 20 1946 James Serry

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 19 46, at 7³⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 19 46, to June 20 19 46, and that I last saw him alive on June 19, 1946 19 46.

Immediate cause of death Sepsis

Due to Red bones

Due to Cerebral Hemorrhage with complete paralysis

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. T. Hubbard M.D.

M. D. or other

Address 312 Ala. Ave. S. E. Date signed 6-20-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 24 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 948

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince George
City or town Clinton Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, institution, or street address where death occurred:
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Clinton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mason C. Walls
4. Sex m 5. Color or race Negro 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Rosa

3. (b) Social Security Number

7. Birth date of deceased (mo., day, yr.) Sept. 1894
8. AGE: Years 51 Months 9 Days If less than one day hrs. min.

8. Birthplace Clinton Maryland
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Farmer

12. Name William Walls
13. Birthplace Maryland
14. Maiden name Marion Hawkins

15. Birthplace Maryland
16. Informant Rosa Walls - Joseph Walls
Address Clinton Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7. 1 46
(month) (day) (year)
Cemetery or crematory F.B. Maryland Pl. N.E.
Location Lee Bee Md. 4339 Hunt Pl. N.E.

18. Funeral director Arthur S. Pollins
Address 4339 Hunt Pl. N.E.

19. 7/1 46 Carrie Campbell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1946 at 1 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27 1946 to June 30 1946
and that I last saw him alive on June 27 1946

Immediate cause of death Angina pectoris
DURATION 3 days

Due to Angina pectoris
Other conditions

(Include pregnancy within 3 months of death)
Major findings of operations none
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. J. Minore M.D.
Address 1619 S. NW Date signed 7-1-46

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 3 1946

BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 06225 245

1. PLACE OF DEATH:

County Prince GeorgeCity or town Riverdale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Leland Memorial HospitalHow long in hospital or institution? 12 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State --- County ---City or town Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)Street No. 3213 Dubois Place, S.E.
(If rural, give LOCATION)2.(a) If veteran, name war ---

3.(a) FULL NAME

(INFANT) JOHN WALSH

3.(b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

6.(c) If alive, give age --- years7. Birth date of deceased (mo., day, yr.) June 1, 1946

8. AGE:

Years

Months

Days

If less than one day

12 hrs. --- min.9. Birthplace Riverdale, Maryland
(Town, county, and state)10. Usual occupation None11. Industry or business ---12. Name Thomas F. Walsh13. Birthplace Mass.14. Maiden name Grace Damon15. Birthplace Mass.16. Informant Thomas F. WalshAddress 3213 Dubois Place, S.E.17. Burial Date thereof 6/4/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mount Olivet CemeteryLocation Washington, D.C.18. Funeral director James A. Ryan, Inc.Address 317 Penna. Ave., S.E.19. June 13 1946 James Sever
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1946, at --- M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-1-1946 to 6-2-1946 and that I last saw h.a.s. alive on 6-2-1946

Immediate cause of death

Congenital bilateral atelectasis of lungs

DURATION

12 hrsDue to PneumoniaDue to ---Other conditions ---

(Include pregnancy within 3 months of death)

Major findings of operations ---Date of op. ---Autopsy results Congenital bilateral atelectasis of lungs
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---Where did injury occur? --- (City or town) (County) (State)Injured at home, farm, industry, public place (where?) ---Means of Injury --- Injured at work? ---23. SIGNATURE C. L. Purdy, M.D.
M. D. or other ---Address 1503 Wood Hobart S.E. Date signed 6-3-46

UNITED STATES DEPARTMENT OF HEALTH

OFFICE OF THE SECRETARY

RECEIVED

JUN 5 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

116226 231
Reg. Dist. No.

1. PLACE OF DEATH: *Prince Georges*
County *Prince Georges*
City or town *Chenery*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *10 hrs. 35 min.*
Hospital, institution, or street address where death occurred:
Prince Georges Hosp.
How long in hospital or institution? *10 hrs. 35 min.*

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State *md.* County *Prince Georges*
City or town *Cheney Largo*
(If outside city or town limits, write RURAL and give nearest town)
Street No. *7400 Largo Rd.*
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME
Whittington, Mr. Richard

3. (b) Social Security Number

4. Sex *m* 5. Color or race *w* 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife *Mrs. Ida Whittington*

7. Birth date of deceased (mo., day, yr.) *June 22 - 1896* 8. (c) If alive, give age years

8. AGE: Years *50* Months Days If less than one day
hrs. min.

9. Birthplace *md.*
(Town, county, and state)

10. Usual occupation *Farmer*

11. Industry or business

12. Name *Richard Edw. Whittington*

13. Birthplace *md. - Anne Arundel Co.*

14. Maiden name *Sarah Ford*

15. Birthplace *Anne Arundel Co., Md.*

16. Informant *Mrs. Ida Whittington*

Address *7400 Largo Rd. Wash. 19*

17. *Burial* Date thereof *6-25-46*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location *Upper Marlboro, Md.*

18. Funeral director *Witchell Bros.*

Address *Upper Marlboro, Md.*

19. *6/25/46* *Amanda Dorney*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *6-25* 19 *46*, at *8:50* AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *19 June* 19 *46*, to *25 June* 19 *46*

and that I last saw him alive on *25 June 46*

Immediate cause of death *Rocky Mountain Spotted Fever*

DURATION *7 days*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *B. J. Casser*

M. D. or other

Address *Upper Marlboro* Date signed *25-6-46*

RECEIVED
JUN 27 1946
BUREAU V.S.